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ABSTRACT

This field hearing included the following issues: (1) the crises facing young children and families; and (2) effective prevention and intervention programs in Los Angeles County. This report of the hearing includes 17 statements and 24 prepared statements, letters, or supplemental materials. Testimony focused on: (1) trends regarding the health of California's children and pregnant women, and services the state offers them; (2) costs and health problems presented by the increasing numbers of pregnant women who receive no prenatal care and of infants exposed to drug use; (3) outcomes of the Newborn Follow-up Project; (4) status of foster care and foster children; (5) problems facing social services that work with families; (6) effectiveness of the Child Welfare and Adoption Assistance Act; (7) emergency shelter for homeless families; (8) the Fragile Infant Special Care Program; (9) the Children's Bureau of Los Angeles Family Connection Project; and (10) early intervention services for infants and families in Los Angeles County. (RJC)

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YOUNG CHILDREN IN CRISIS: TODAY'S PROBLEMS AND TOMORROW'S PROMISES

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HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

HEARING HELD IN LOS ANGELES, CA, APRIL 15, 1988

Printed for the use of the
Select Committee on Children, Youth, and Families

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YOUNG CHILDREN IN CRISIS: TODAY'S PROBLEMS AND TOMORROW'S PROMISES

FRIDAY, APRIL 15, 1988

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC.

The Select Committee met, pursuant to notice, at 9:54 a.m. in the Board Room, Room H-160, Los Angeles Unified School District, North Grand Avenue, Los Angeles, California, Hon. George Miller presiding.

Members present: Representatives Miller and Dreier.

Also present: Michael Antonovich, Los Angeles County Supervisor.

Staff present: Ann Rosewater, staff director; Karabelle Pizzigati professional staff; and Robert Woodson, Jr., research assistant.

Chairman **Miller**. The Select Committee on Children, Youth, and Families will come to order. I am pleased to bring the Select Committee on Children, Youth, and Families to Los Angeles for this hearing to examine both the crises facing young children and families and programs that work to prevent and lessen those problems. It is timely that this field hearing is occurring during the Week of the Young Child, an annual celebration focusing on the attention of the needs of our youngest citizens.

Here in Los Angeles County, we see a microcosm of our nation's challenges and successes to assure healthy development in children and their families. Approximately one out of every thirty U.S. children lives in Los Angeles County and one-fifth of them grow up in low-income families. 20 percent of young Los Angeles children are not immunized against all major childhood diseases and in a two-year period, the number of children entering County Emergency Protective Services rose nearly 40 percent to more than 103,000.

In Los Angeles County and across the country, these conditions forewarn mounting and costly problems. More babies born to low-income, uninsured women, and to women relying on Medi-Cal; babies beginning their lives in hospital intensive care units; greater numbers of pregnant women who use drugs and whose babies are born with serious complications.

Even when these babies are born healthy, assuring their future health and family stability continues to present great challenges. Services that provide such assurance in Los Angeles County, like elsewhere, fall far short of the need and the demand. And, an increasingly diverse and growing ethnic population county and statewide, requires culturally sensitive services.

Most Los Angeles families who must juggle the dual responsibilities of childrearing and work need safe and affordable child care. But, as the Little Hoover Commission reported in 1986, more than 51,000 Los Angeles families were on waiting lists for child care and only 7 percent of the eligible children Statewide received subsidized care.

The tragedy is that the longer vulnerable children and vulnerable families lack these essential services, the more intractable and costly their needs become to address. The Select Committee's recently released report, "Opportunities for Success: Cost Effective Programs for Children," reinforces our knowledge that preventive programs save lives, save dollars. This is again confirmed by the Southern California Child Health Network's findings, that California could save at least $30 million annually if it provided prenatal care to 36,000 pregnant women who now go without it.

We must act on that knowledge now. Early intervention has tremendous appeal here in Los Angeles, due to the sheer number of lives that we can salvage, and because of the significant risks—including child abuse, AIDS, and gang violence—facing the community's youngest citizens. I applaud the initiatives which local officials have already taken by committing more than one million dollars to prenatal care services and launching a major child care initiative at the County USC Medical Center. The City of Los Angeles is also moving in the right direction by hiring a child care coordinator and I encourage these efforts.

I would particularly like to thank this morning County Supervisors Ed Edelman and Michael Antonovich. Mike has already joined us in the Committee. I appreciate their commitment and their help in setting up this hearing and extending an invitation to the Select Committee to come to Los Angeles to hear testimony first-hand, and to engage in some site visits as we did this morning where we visited the programs at Para Los Ninos. It was very impressive to me in terms of the comprehensive range of services that are provided, not only to the children, but to their families. I would like to also extend my thanks to the School Board members and to Superintendent Leonard Britton for the help that the Los Angeles Unified School District has given us to put this hearing together and allowing us to use this facility.

[Prepared statement of Hon. George Miller follows:]

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

I am pleased to bring the Select Committee on Children, Youth, and Families to Los Angeles for this hearing to examine both the crises facing young children and families and the programs that work to prevent and lessen those problems.

It is timely that this field hearing is occurring during the "Week of the Young Child"—an annual celebration focusing attention on the needs of our youngest citizens. Here in Los Angeles County, we see a microcosm of our Nation's challenges and successes to assure healthy development of children and their families.

Approximately one in every 30 U.S. children lives in Los Angeles County, and one-fifth of them grow up in low-income families. Twenty percent of young Los Angeles children are not immunized against all the major childhood diseases. And in a two year period, the number of children entering county emergency protective services rose nearly 40 percent, to more than 103,000.

In Los Angeles County and across the country, these conditions forewarn mounting and costly problems: more babies born to low-income, uninsured women and to women relying on Medi-Cal, babies beginning their lives in hospital intensive care units, greater numbers of pregnant women who use drugs, and whose babies are born with serious complications.

Even when these babies are born healthy, assuring their future health and family stability continues to present great challenges. Services that provide such assurance in Los Angeles County, like elsewhere, fall far short of need and demand. And an increasingly diverse and growing ethnic, population county and statewide, requires culturally sensitive services.

Most Los Angeles families who must juggle the dual responsibilities of childrearing and work need safe and affordable child care. But, as the Little Hoover Commission reported for 1986, more than 51,000 Los Angeles families were on waiting lists for child care, and only 7 percent of the eligible children statewide received subsidized care.

The tragedy is that the longer vulnerable children and vulnerable families lack these essential services, the more intractable and costly their needs become to address. The Select Committee's recently released report, "Opportunities for Success: Cost Effective Programs for Children," reinforces our knowledge that preventive programs save lives and save dollars too. This case has also been confirmed by the Southern California Child Health Network's finding that California would save at least $30 million annually if it provided prenatal care to the 36,000 pregnant women who now go without it.

We must act on that knowledge now. Early intervention has tremendous appeal here in Los Angeles due to the sheer number of lives we can salvage, and because of the significant risks including drug abuse, AIDS and gang violence facing the community's youngest citizens. I applaud the inititatives which local officials have already taken by committing one million dollars to prenatal care services and launching a major child care initiative at the County/USC Medical Center. The City of Los Angeles is also moving in the right direction by hiring a city child care coordinator. I encourage these efforts.

I would like particularly to thank County Supervisors Ed Edelman and Michael Antonovich for joining the Committee for our hearing today. We appreciate their commitment to children and the invitation to the Select Committee to come to Los Angeles. The Los Angeles Children's Services Commission has played an invaluable role in putting this hearing together and we are very much in their debt. In addition, I would like to express my appreciation to school board members and Superintendent Leonard Britton, of the Los Angeles Unified School District, for welcoming us and allowing us to hold this hearing here.

Today we will hear from those who have experienced and worked on these issues firsthand. I want to welcome and thank all the witnesses for taking the time to appear before the Committee.

FACT SHEET
"YOUNG CHILDREN IN CRISIS: TODAY'S PROBLEMS AND TOMORROW'S PROMISES"

CHILDREN IN CALIFORNIA

- In 1986, 482,000 babies were born in California, 1 of every 8 babies born in the United States. Approximately 80,000 more babies were born in 1986 than in 1980, a 20% increase. (Southern California Child Health Network, Children's Research Institute of California [SCCHN], 1988)

- In 1980, there were 2 million children aged 0-17 in Los Angeles County, 3% of the nation's total child population (63 million).

  Sixty-one percent of all LA County children are non-white. The largest single group is Hispanic, accounting for 4 out of 10 children. (U.S. Bureau of the Census, 1980; Los Angeles Roundtable for Children [LA Roundtable], 1984)

- In 1980, almost 1/5 of LA County's children lived in households with incomes below poverty. In FY 1984, more than 2/3 (68%) of AFDC recipients in Los Angeles were children. Between FY81 and FY84, there was a 6% increase in the total number of AFDC recipients. (LA Roundtable, 1984)

GROWING NUMBER OF CHILDREN AT RISK OF POOR HEALTH

- Among the 20 largest U.S. metropolitan areas, Los Angeles-Long Beach has the largest percentage of uninsured adults and the second largest percentage of uninsured children. (California Policy Seminar [CPS], 1987)

- In 1986, California experienced increases in births to mothers in each of three high-risk categories: age 17 or younger; age 35 or over; or between the ages of 18 and 34 who received late or no prenatal care. Nearly 91,000 babies in California -- one in every five -- were born to high-risk women, a 14% increase from 1984 to 1986. (SCCHN, 1988)

- The number of children eligible for California's medical program for disabled children increased by 14% between FY86 and FY87, and is projected to grow 28% by FY89. Program administrators report that resulting higher expenditures are due to an increase in infants born prematurely or at low birthweight and without adequate prenatal care. (SCCHN, 1988)

- Children in foster care in Los Angeles have significantly more health problems than other children of comparable ages, including growth retardation; decayed teeth; and inadequate immunization. Ten percent of children in shelter care in Los Angeles have a severe or chronic medical condition. (United Way of Los Angeles [UWLA], 1987; California Foster Care Network [CFCN], 1985)

- Foster children often fail to receive comprehensive and continuous health care in LA due to a shrinking pool of private physicians and dentists willing to treat foster children; inadequate medical-records; and inadequate monitoring that results in postponed or duplicated health exams. (UWLA, 1987)

SUBSTANCE ABUSE, LACK OF PRENATAL CARE POSE THREATS TO INFANTS

- In Los Angeles County, the number of babies reported to county authorities because of drug withdrawal at birth increased by 183% between 1984 and 1987. (SCCHN, 1988)
- While drug abuse is growing in California, alcohol remains the most frequently abused substance, affecting over 4,000 newborns each year. (SCCHN, 1988)
- In California, the percentage of women receiving late or no prenatal care grew from 7.2% in 1984 to 7.6% in 1985. In 1985, rates of late or no prenatal care were 10.8% for Hispanics; 9.3% for blacks; 6.2% for Asians; and 4.8% for whites. (SCCHN, 1988)
- California babies born to mothers who receive late or no prenatal care are five times more likely to die than babies born to mothers receiving adequate care. In 1985, California's infant mortality rate increased for the first time since 1965 to 9.5 deaths per 1,000 live births. (Dallek, 1987; SCCHN, 1988)
- In 1984, nearly 16% of patients delivering in Los Angeles County public hospitals received late or no prenatal care compared to 6% delivering in the County's private hospitals. In 1985, the infant mortality rate in LA County was 10.3 deaths per 1,000 live births. (Dallek, 1987; SCCHN, 1988)

CALIFORNIA CHILDREN WAIT FOR CHILD CARE

- In 1986, 51,326 Los Angeles County families were on waiting lists for child care. (California Child Care Resource and Referral Network, 1987)
- Only 7% of the 1.1 million children eligible for State subsidized child care receive it. (Commission on California State Government Organization and Economy [Little Hoover Commission], 1987)

REPORTS OF CHILD ABUSE GROW; MORE CHILDREN IN FOSTER CARE

- In California, the child abuse and neglect reports increased from 73,473 in 1982 to 342,001 in 1986, a 365% increase. Calls to the Los Angeles County Department of Children's Services child abuse hotline were up more than 200% from 1981-1986. (Little Hoover Commission, 1987; Interagency Council on Child Abuse and Neglect, County of Los Angeles, 1987)
- The number of dependency judicial reviews in Los Angeles increased from 11,610 in FY82 to 38,215 in FY87, a 229% increase. (Little Hoover Commission, 1987)

- * California counties report increased shelter care admissions of infants and young children. One county reports that 40% of their shelter children are under age 6; another has over 100 infants in shelter care -- most are diagnosed as failure-to-thrive or have drug-dependent mothers. The average length of stay for a child in shelter care, a system designed to be temporary, is nearly 40 days. (CFCN, 1985)

SYSTEMS STRAINED, OVERWORKED, UNDERFUNDED

- * In Los Angeles, 90% of children removed from their homes after normal working hours at social service agencies were detained and placed into emergency shelter care with limited social worker involvement. (Bay Area Foster Care Network, Children's Research Institute of California [BAFC], 1987)
- * Between 1980 and 1984, the caseloads of child welfare workers in Los Angeles County rose more than 52%. (LA Roundtable, 1986)
- * In FY 84, only 5% of expenditures for child protection in Los Angeles went toward prevention and early intervention. By contrast, protective services accounted for 85% and dependency court processes, 10%. (LA Roundtable, 1986)

Chairman **Miller**. Congressman Martinez, I think, will be joining us later. I would like again to welcome Supervisor Mike Antonovich to the Committee and Mike, if you have a statement that you would like to make, I would more than welcome it.

STATEMENT OF MICHAEL D. ANTONOVICH, LOS ANGELES COUNTY SUPERVISOR, LOS ANGELES, CA

Mr. **Antonovich**. Thank you very much and thank you for this opportunity to also be a part of this hearing.

As you state, the family is the basic block of our society and to cripple the family, we cripple our nation.

One in every 30 United States children resides in Los Angeles County. A serious problem which parents face today is that allowable tax deductions for parents with children have not kept up with the rate of inflation. Within a few years, two-thirds of all preschool children will have working parents creating an additional burden for families due to the cost and the limited choices for available child care placement. There is a need to establish Federal tax credits for child care to ease the burden for single parents and families with two working parents.

The County Department of Children's Services places approximately 1100 children each month in foster care. Approximately one-third of these children are abused. There is a critical need to recruit quality foster and adoptive parents in an effort to provide this strong, stable family while these children can have the opportunity of preparing a strong foundation for their future. There is a need to provide foster and adoptive parents with economic incentives in order to facilitate our recruitment efforts. Increased tax deductions would provide a possible incentive.

While the young people are our future, it is critical that we take every precaution to provide a healthy and caring environment.

Another problem we have in Los Angeles County is the number of runaways. We now receive over 300 runaways each week. This past Christmas, I had the opportunity of participating with the Ride-A-Long with the Los Angeles Police Department which included representatives from the State. We observed the runaways living in the streets in vacant buildings in the Hollywood area, many who are leading a dangerous lifestyle, often being led into drugs and prostitution. And, it is stated, that if a child is on the street for more than three days, they are basically lost and will never be able to be rehabilitated.

Clearly, there is an urgent need to address the problem of runaways in Los Angeles by changing the Federal Juvenile Delinquency and Prevention Act of 1984 which prevents runaways from being returned to their homes or a suitable placement.

Drug addiction is also undermining the family. The United States needs to get tough on the drug pushers who are undermining our schools. International sanctions must be imposed against drug exporting nations. We need to consider the development of an economic plan similar to the successful Marshall Plan of World War II which will replace crops of death with crops of life. Last week our Board unanimously voted to increase the Federal drug enforcement resources for the County due to the international explosion of international drug trafficking through this area. New York currently has over 200 United States attorneys working in the prosecution of cases in their cases. Los Angeles only has 68. We need to have additional resources to combat this evil.

Los Angeles County spent over $42 million last year for the 1800 infants who are born as addicts. These are addicts in diapers. Mothers who are addicts have created these children and these children are surely victims of child abuse in the most tragic form and that is not counting the loss of opportunity that these people could have contributed to the society had they been born healthy.

As I say, our children are our future—it is very critical that we take the precautions to provide a healthy and caring environment for the children. Thank you again for the opportunity.

[Prepared statement of Michael D. Antonovich follows:]

Prepared Statement of Michael D. Antonovich, Los Angeles County Board of Supervisors, Los Angeles, CA

WELCOME.

THE FAMILY IS THE BASIC BLOCK OF OUR SOCIETY...IF WE CRIPPLE THE FAMILY, WE CRIPPLE OUR NATION.

- ONE IN EVERY 30 U.S. CHILDREN LIVES IN LOS ANGELES COUNTY.
- A SERIOUS PROBLEM WHICH PARENTS FACE TODAY IS THAT ALLOWABLE TAX DEDUCTIONS FOR PARENTS WITH CHILDREN HAVE NOT KEPT UP WITH THE RATE OF INFLATION.

- WITHIN A FEW YEARS TWO-THIRDS OF ALL PRESCHOOL CHILDREN WILL HAVE WORKING PARENTS, CREATING AN ADDITIONAL BURDEN FOR FAMILIES DUE TO THE COST AND LIMITED CHOICES FOR AVAILABLE CHILD CARE PLACEMENTS.

THERE IS A NEED TO ESTABLISH FEDERAL TAX CREDITS FOR CHILD CARE TO EASE THE BURDEN FOR SINGLE PARENTS AND FAMILIES WITH TWO WORKING PARENTS.

- THE COUNTY DEPARTMENT OF CHILDRENS SERVICES PLACES APPROXIMATELY 1100 CHILDREN EACH MONTH IN FOSTER CARE.

* THERE IS A NEED TO PROVIDE FOSTER AND ADOPTIVE PARENTS WITH ECONOMIC INCENTIVES IN ORDER TO FACILITATE OUR RECRUITMENT EFFORTS.

INCREASED TAX DEDUCTIONS WOULD PROVIDE A POSITIVE INCENTIVE.

* APPROXIMATELY ONE-THIRD OF THESE YOUNG PEOPLE ARE ABUSED CHILDREN.

OUR LOS ANGELES COUNTY DEPARTMENT OF CHILDREN SERVICES RECEIVED OVER 100,000 REFERALS FOR PHYSICAL AND SEXUAL ABUSE LAST YEAR.

*THERE'S A CRITICAL NEED TO RECRUIT QUALITY FOSTER PARENTS IN AN EFFORT TO PROVIDE A STRONG, STABLE FAMILY WHERE THESE CHILDREN CAN BUILD A FOUNDATION FOR THEIR FUTURE.

*MANY CHILDREN NEVER RECEIVE THAT OPPORTUNITY TO BE CARED FOR.

*OVER 300 RUNAWAYS ARRIVE IN LOS ANGELES COUNTY EACH WEEK.

*THIS PAST CHRISTMAS I HAD THE OPPORTUNITY TO RIDE-ALONG WITH THE LOS ANGELES POLICE DEPARTMENT TO OBSERVE THE RUNAWAYS LIVING IN THE STREETS AND VACANT BUILDINGS IN THE HOLLYWOOD AREA, MANY WHO ARE LEADING A DANGEROUS LIFESTYLE, OFTEN BEING LED INTO DRUGS AND PROSTITUTION. THIS IS SOCIALLY AND MORALLY UNACCEPTABLE.

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*CLEARLY, THERE IS AN URGENT NEED TO ADDRESS THE PROBLEM OF RUN-AWAYS IN LOS ANGELES BY CHANGING THE FEDERAL JUVENILE DELINQUENCY AND PREVENTION ACT OF 1984 WHICH PREVENTS RUN-AWAYS FROM BEING RETURNED TO THEIR HOMES OR A SUITABLE PLACEMENT.

*DRUG ADDICTION IS UNDERMINING THE FAMILY.

*THE UNITED STATES NEEDS TO GET TOUGH ON DRUG PUSHERS WHO ARE UNDERMINING OUR SCHOOLS. INTERNATIONAL SANCTIONS MUST BE IMPOSED AGAINST DRUG EXPORTING NATIONS. WE NEED TO DEVELOP AN ECONOMIC PLAN SIMILAR TO SUCCESSFUL MARSHALL PLAN TO REPLACE THE CROPS OF DEATH WITH CROPS OF LIFE. LAST WEEK, THE BOARD VOTED UNANIMOUSLY TO INCREASE FEDERAL DRUG ENFORCEMENT RESOURCES FOR LOS ANGELES COUNTY DUE TO THE RECENT EXPLOSION OF INTERNATIONAL DRUG TRAFFICING THROUGH THIS AREA. NEW YORK HAS OVER 200 U.S. ATTORNEYS WHILE THE WESTERN STATES HAVE ONLY 68. LAST YEAR, THE BOARD OF SUPERVISORS APPROVED MY MOTION TO ASSIGN AN ADDITIONAL FULL TIME DISTRICT ATTORNEY TO WORK WITH THE U.S. ATTORNEY IN PROSECUTING DRUG PUSHERS WHO PEDDLE NARCOTICS NEAR OUR SCHOOLS.

*LOS ANGELES COUNTY SPENT OVER 42 MILLION DOLLARS LAST YEAR TO TREAT ADDICTS IN DIAPERS...INFANTS BORN ADDICTED TO DRUGS BECAUSE THEIR MOTHERS ARE DRUG ADDICTS. THESE TINY INFANTS ARE SURELY VICTIMS OF CHILD ABUSE IN ITS MOST TRAGIC FORM.

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- THE YOUNG PEOPLE ARE OUR FUTURE. IT IS CRITICAL THAT WE TAKE EVERY PRECAUTION TO PROVIDE A HEALTHY AND CARING ENVIRONMENT.

Chairman **Miller**. Thank you. I want to tell you how much I appreciate your taking some of your time today to sit with us for awhile and listen to the testimony.

I also want to thank the Los Angeles Children's Services Commission for all of the help that they have provided the Committee in helping us to locate witnesses and to talk with people throughout the County about this hearing.

At this time, we will call our first panel which will be made up of Rhea Perlman who is an actress and parent from Los Angeles, Gilda Hines who is a parent from Inglewood and Bernesteen Robinson who is a foster parent from Los Angeles. If you will come forward, we will take your testimony in the order in which I called you and your written statement will be placed in the record in its entirety. You can proceed in the manner in which you are most comfortable. I just want to see if I can see you. I am not used to the set-up they have here. Maybe things get so hot at the School Board, they are afraid people will jump over or something.

Ms. **Perlman**. Select Committee——

Chairman **Miller**. That is right. Rhea, we will start with you. Thank you very much for taking your time to be with us. Proceed in the manner which you would like.

Ms. **Perlman**. You are welcome. Am I testifying to you?

Chairman **Miller**. You are testifying to us.

Ms. **Perlman**. Not to them.

Chairman **Miller**. No.

Ms. **Perlman**. That they are just——

Chairman **Miller**. Yeah, right.

Ms. **Perlman**. I have never done this before but I am going first. I do not know what I am doing. Okay.

STATEMENT OF RHEA PERLMAN, ACTRESS AND PARENT, LOS ANGELES, CA

Ms. **Perlman**. My name is Rhea Perlman. I am an actress and a mother and for the last three years I have been working towards trying to increase people's awareness that there is a child care crisis in this Country so I am happy to be here and be able to talk to you about all kinds of kids and families and what I have come to believe is their right to quality child care.

I think that once a kid is born, it becomes all of our responsibility because the children are the work force of the future, they are the future, and it just makes sense to take care of them when they are little and then we do not have to get into cleaning up the mess later on. I think it just makes sense.

In most families these days, both parents have to work and there are more and more single parent families. Parents are forced to scramble for whatever kind of daycare they can find which, very often, means leaving kids in undesirable situations; in dangerous situations, dirty situations, incompetent situations and unconstructive situations. Because there is very little affordable quality daycare out there. It sometimes means finding nothing and having to quit a job and go on welfare to take care of the child which just seems like a ridiculous catch-22 to me.

Traditionally, parents have not felt that they could speak out about this problem and call for help from the people who could help them which are their employers and their government officials. The reason that they have not is because they, along with their bosses and government, are still under the impression that they should be living the life of Leave it to Beaver and feel guilty that they are not. I think, as most of us know, this is a life that never existed except on network TV.

Now, people have to get real and accept this as a number one problem. We must have a national policy of child care so that when parents return to work, their children are guaranteed a place in a licensed, quality daycare center so these kids are not left to fend for themselves and can grow up to their full potential.

And then, to come to what this meeting is all about, families with special needs and how daycare can help them in particular. First of all, for children living in poverty, quality daycare can provide an opportunity for parents to find a job. They can leave their kids someplace. They can have peace of mind that somebody is watching their children and they can have the time to go out and look for a job or enter some kind of job training programs where they can develop skills that they need for work. It can also help prevent malnutrition by providing balanced meals; breakfast and lunch and snacks. The same goes for children of teenaged parents. It gives them an opportunity to train for jobs that they find themselves, you know, in the workforce with absolutely no idea of what they can possibly do and a little kid. This leads to very, very stressful situations.

It also can provide the child a safe environment to move about in and explore while, you know, at home, things might not be up-to-par. Quality child care can also provide early identification of developmental problems like speech, movement or learning difficulties. It can even help prevent disabilities such as mental retardation through intervention services for children who are being brought up in nonstimulating environments, for instance, without toys, which can severely retard their development, if not corrected, for life.

For children who have been in danger of abuse or are being abused, daycare can help prevent abuse through trained daycare providers identification of the danger signs. It can provide a rest if the parent is under extreme stress. It can be a support system for families, a place where parents can vent their feelings and concerns. It can help prevent unnecessary out-of-home placement, keeping the family together wherever possible. I think that is real important.

I feel that it is really important that we put some time and thought and money into caring for kids when they are young, to give them a sense of self-worth when maybe they would not be able to come to that at their homes or in their neighborhoods. They really need somebody out there directing them and making them feel good about themselves, making them feel they can do anything they want to later on in life, so they can be viable citizens. Maybe then, we can be spending less money on additional police to control gangs and less money on courts and prisons and less for welfare.

Chairman **Miller**. Thank you.

Ms. PERLMAN. You're welcome.

Chairman MILLER. Thank you. Gilda.

Ms. HINES. I am sorry. I am Gilda.

Chairman MILLER. Yes.

STATEMENT OF GILDA HINES, PARENT, INGLEWOOD, CA

Ms. HINES. OK. Respite Care Program helped me and my children adjust and find normalcy which was badly needed after the ordeal of going to court with a charge against my brother who had sexually abused my daughter who was four years old. I did not know how far the abuse went until it was brought in court and I found out that my two-year old son was to be his next victim. I was in the dark about so many things and I felt like I failed my children as well as my marriage. I divorced at this time.

A part of me wanted to go under a rock and another part of me felt like my children really needed some help. I felt abandoned by the court and by my family that day. I had hope, when this matter went to court, that everything could make more sense but it did not. Now, I had a new problem. Where would my children go. They love their grandparent very much and it was hard to tell them that they could not live there anymore. We were living with them and my brother at the time.

My temporary babysitting arrangement had run out. My grandmother of 80 years old could no longer meet the physical and the psychological demands of keeping up with two active children all day. There was not enough money from my low paying job to cover the cost of child care for two children. No one else in the family or friends wanted to be around a child like my daughter in the fear that she would accuse them of sexual abuse or inflict their children with the abuse she has suffered.

But God was on our side because at the courtroom door, someone told me about the program Crystal Stairs and out of desperation, I went to their office. Now, I realize it must have taken a lot of patience and understanding to get the information needed to process the paperwork. I was still in shock from the courtroom experience and from the fact that my children had been in danger when I felt that they were safe. My main concern was to make sure that my children also felt safe and loved. The program shared the same concern. They gave me selection of child care centers so that I could make my own choice with the understanding that the children's welfare was the most important factor in the choosing of child care facility. They asked me and offered benefit and aid for my family, including reference to doctors, food and clothing. They seemed to have an endless resource to draw from. Thanks to the program, I am able to stay on my job. My daughter and I are going to counseling.

I, too, have been raped in the early twenties and felt extremely helpless to deal with this, my daughter's trauma. I am using the counseling to keep myself centered in order to go on forward in a positive way.

My son, now four years old, is going—excuse me. All right. My son, now four years old, is going to a speech therapist. I might have never realized that he had a speech problem but because of the program, we were able to help him before entering public school. Both my children are learning to interact with other children their own age and we seem to be on the road to a normal life.

[Prepared statement of Gilda Hines follows:]

PREPARED STATEMENT OF GILDA HINES, PARENT, INGLEWOOD, CA

April 15, 1988

Testimony for the House Select Committee on Children, Youth and Families concerning the role of preventive/interventive child care (Respite Care).

By Gilda Hines, a parent served by the Respite Care Program at Crystal Stairs, Inc.

Crystal Stairs' Respite Program helped me and my children readjust and find normalcy which was badly needed after the ordeal of going to court with charges against my brother who had sexually abused my daughter who was four years old. I did not know how far the abuse went until it was brought up in court and I found out that my two year old son was to have been his next victim. I was in the dark about so many things asnd I felt like I had failed my children as well as my marriage which was ending in divorce at the same time.

A part of me wanted to die under a rock and the other part of me needed to know what would become of my children. I felt abandoned by the courts and my family that day.

I had hoped when this matter went to court that everything would make more sense. But, it didn't. Now, I had a new problem. Where would my children go? They loved their grandparents very much and it was hard to tell them that we could no longer live with them. We were living with them and my brother at the time that the abuse occurred. My temporary babysitting arrangements had run out. My grandmother of 80 years could no longer meet the psychological and physical demands of keeping up with two active children all day. There was not enough money coming from my minimum wage job to cover the costs of child care for two children and no one else in the family or friends wanted to be around a child like my daughter in the fear she would accuse them of sexual abuse or infect their children with the abuse that she had suffered.

But God was on our side because it was at the courtroom door that someone told me about the program at Crystal Stairs. Out of desperation, I went to their offices.

I realize now it must have taken a lot of patience to understand me and to get the information needed to process the paperwork. I was still in shock from the court experience and from the fact that my children had been in danger when I felt sure that they were safe. My main concern was to make sure that the children also felt safe and loved. The Respite program shared the same concerns. They gave me a selection of child care centers so that I could make my own choice with the understanding that the children's welfare was the most important factor in the choosing of a child care facility. They asked and offered other benefits or aids for my family including referrals to doctors, food and clothing. They seemed to have endless resources to draw from.

Thanks to the program, I was able to stay on my job. My daughter and I are now going for counselling. I too had been raped in my early 20's and felt extremely helpless to deal with my daughters trauma. I am using the counselling to keep myself centered in order to keep going forward in a positive direction. My son is now four years old and is going to a speech therapist. I might have never realized that he had a speech problem but because of the program, we will be able to help him before he enters public school. Both of my children are learning to interact with other children their own age. And we seem to be on the road to a normal life.

Chairman **Miller**. Thank you very much. Bernesteen.

STATEMENT OF BERNESTEEN ROBINSON, FOSTER PARENT, LOS ANGELES, CA

Ms. **Robinson**. My name is Bernesteen Robinson. I would like to tell the story of what happened when I took custody of my three nieces and nephew.

Their mother left me with them because she could not handle them. All of them were badly abused. The youngest child, Amelia, was 22 months old. She was afraid of being touched by me because I was a stranger. She had also been badly abused by her older sisters and was terrified of everyone. The little boy, Elijah; he was six. He was a very smart little boy. He had a speech problem and bad behavioral problems. Upon getting upset, he would set fires.

The children's service worker kept promising to get me psychiatric care for the children. They needed medication and special education. I also needed foster care benefits because I had to quit the little jobs that I was working on like maybe one day or two days a week to help supplement the small amount of income that I was getting.

Upon leaving the children with babysitters, the older girl, with her bad behavioral problems, would jump on the babysitter or start a fight with them which caused me to come home and to stay with them.

The workers kept promising to get special help for the children but they never did. All the help that I got was through resources and various information from friends, et cetera. The kids—the help that I received was through praying for myself. I never did get the foster care benefits and since I could not work and I kept losing houses, the children are now with their grandmother which I hope to get back soon. I still need the help at this time. Thank you.

[Prepared statement of Bernesteen Robinson follows:]

Prepared Statement of Bernesteen Robinson, Foster Parent, Los Angeles, CA

I'd like to start my story by telling this committee how I got custody of my three nieces, Emma, Shante and Amelia and one nephew, Elijah. Both of the older girls had been sexually abused. One of their younger brothers died of suspected child abuse. Although all four of the children had severe emotional problems, I am going to talk most about the two youngest children, Amelia and Elijah.

Around July of 1984, my sister, the mother of these four children, started leaving them with her boyfriends. One of the older girls complained to me that her mother's boyfriend was forcing her to have sex with him and was giving her drugs. I called the Department of Children's Services and reported this to them and they went out to investigate but they let the children stay in their mother's home.

On August 8, 1984 my sister brought the children to my home and abandoned them there. She informed the Department of Public Social Services (DPSS) that I had the children, and a children's services worker came out to my house to see the children.

Amelia was around 22 months old when she came to live with me. She had recently been treated at a hospital for rat poisoning. She was frightened of everyone except for her sisters and brother. She wouldn't let me hold her. I believe that some of her problems may have been caused by the fact that her mother used cocaine, marijuana, and alcohol while she was pregnant with Amelia. Amelia's stomach was enlarged and she seemed to be malnourished. Both of her wrists were severely scarred because her eldest sister had bitten her over and over.

Elijah was around 6 years old when he came to live with me. He was very underweight. He was a good little boy and very smart, but when he got upset he set fires. He was withdrawn and had a speech problem. He would wet his bed at night. He and his older sisters had violent fights with each other all the time.

When I gave Elijah and Amelia toys to play with they would immediately break them apart. When I gave Amelia dolls, she would pretend to beat them up and yell at them. Often, she would pull them apart. It was like she was punishing them for something.

The children had a lot of different children's services workers. They said that they would file a petition with the court so that I would have legal custody of the children. They promised me that then the children would get the psychiatric help they need but every time I called the worker they would just say they were working on it. Then, I wouldn't hear from them again. The children had been through so much. They really needed help.

The social workers also told me that I would receive foster care benefits for the children. I needed this extra money because when the children came to live with me they caused such problems in the building I was living in that I had to move into a different three bedroom house.

I kept calling the children's services workers assigned to the case but nothing was happening. It was more and more clear that the children needed psychiatric help very badly. I found a psychologist who would take Medi-Cal stickers, but she would only see the children once or sometimes twice a month. They needed much more help than that. Finally a friend put me in touch with a psychologist who came out to see the children every Saturday, even though Medi-Cal did not cover all of his time.

All the children, including Elijah and Amelia, needed 24 hour supervision, because if they were left alone, they would set fires or start fighting with each other or destroy things around them. I couldn't leave the children for long periods of time with a babysitter because the eldest girl would start beating up the babysitter. This made it harder and harder for me to go to my job. I worked cleaning peoples' houses, just trying to make ends meet. I tried to bring the children to work with me but they would make obscene noises, fight and destroy things that they found lying around.

One day I left the children at home with a babysitter. The older girl started to run into the street. The babysitter went after her, leaving the younger children alone. When I heard what happened I became afraid for the children. I felt like I had no choice; I had to quit my job and go on federal AFDC.

Throughout all this, I kept calling the children's services workers asking for help for the children and asking when the court hearing would take place. When nothing happened I filed for a State fair hearing. A representative from the County then contacted me and said that she would file the court petition and that the children would get the services and foster care benefits they needed.

On July 10, 1985, the County filed the dependency petition for the children. The next day, the judge signed the order making the children dependents of the court. The Children's Services worker told me they would evaluate the children's application for foster care benefits again and that the children would start getting all the special services they needed.

Later that month, the County denied the children's applications for AFDC-FC benefits because they said the court petition wasn't filed on time. I filed for another State hearing. The hearing officer found in my favor but then the Director of the California Department of Social Services reversed the hearing officer's decision. The case is in court now.

Even after all this the children never received any mental health services from the County at all. One of the Children's services workers told me that Elijah needed a really thorough psychiatric evaluation but he has never received it. I know that he remembers his brother who died. I know he needs more help than he's getting.

To this day, the same problems exist. The children are now staying with their grandmother because I could not support them. They aren't getting any help for the terrible emotional problems they have. I feel so frustrated; I tried to do everything I could to help these children. I love them and I know they are good kids, but they have been through so much and the system has just failed them. Maybe my testimony won't help my children but at least I can try to help someone else's children to not have to go through this. I thank this Committee for inviting me here to testify today and I hope you can do something so that other children can get the help and aid they need in order to grow up to be successful happy adults.

Chairman **Miller**. Thank you.

Gilda, who told you about the Crystal Stairs program?

Ms. **Hines**. Well, it is kind of peculiar because you have to realize, a lot of people came to the court hearings. I do not know who they were. After the court thing, I was like standing there. I really was literally standing there and so and so said what is the matter. And I said well, I want to go to work Monday and I do not know what I am going to do with my kids. So, they said, well, do you know that there is a Crystal Stairs not too far from the courthouse that could help you. I go regularly. It was that type of situation. I do not know who it was who told me about the program.

Chairman **Miller**. So, it was simply an accident.

Ms. **Hines**. Yes.

Chairman **Miller**. But had that accident not happened, there was no formal arrangement.

Ms. **Hines**. No.

Chairman **Miller**. To take care of you in your situation or provide you some access to resources.

Ms. **Hines**. Not even, I guess you call him the Defender, who was doing the case for me, she did not say anything. She said, oh, no one will let my brother go. And she feels so sorry and if you need any help just call me and I looked around and she was gone. I mean there I am going, well, what——

Chairman **Miller**. What was that number again.

Ms. **Hines**. Yes.

Chairman **Miller**. So that, as traumatic as the case is with your daughter and your son, and going through a formal procedure such as the court, there was no effort to try to provide referral for you to another program of any kind.

Ms. **Hines**. None. Not even for the emotional care of my child they told me she was to get. She did not.

Chairman **Miller**. Now, you are working now?

Ms. **Hines**. Yes, I am.

Chairman **Miller**. Can I ask you how much you are making?

Ms. **Hines**. Four fifty.

Chairman **Miller**. Four fifty an hour. So you are still making four fifty an hour. So, obviously—yeah, right. It is so obvious I do not have to ask the question.

Ms. **Hines**. No.

Chairman **Miller**. There is no ability to find other sources of child care.

Ms. **Hines**. No, none at all.

Chairman **Miller**. Or to pay for them.

Ms. **Hines**. No.

Chairman **Miller**. What is the alternative to the work for you?

Ms. **Hines**. The County. They will take—there is no—there are no medical benefits on my job. No dentist I mean, my son spent a week in the hospital, County Hospital. $500, and at that time, I was just totally going, there is no money. So I have to figure out a way to pay them off. You know, but, there is nothing. In case of an emergency, there is nothing. There is just totally nothing.

Chairman **Miller**. Bernesteen, have you taken care of foster children before these two children that you had.

Ms. **Robinson**. Four.

I had four of them.

Chairman **Miller**. You had four of them.

Ms. **Robinson**. I had four of them, yes, uh-huh. Yes, I had. I have three personal children of my own who are grown at this time, who are adults at this time. I have worked in the community with children from all walks of life; hard core gangs, youth, et cetera.

Chairman **Miller**. Now, is this—we had hearings in Washington, D.C., the day before yesterday.

Ms. **Robinson**. Uh-huh.

Chairman **Miller**. And I was talking to a foster parent there who has had, I think 49 foster children. She is sort of a legend in Washington. She has continuously encountered the problem of foster care payments not coming forth on time and having to provide, by herself the costs of care for these children. When you care for many of these children, and pay for either for clothing or for food, or what have you, you Simply, never catch up. Has that been your experience also?

Ms. **Robinson**. Well, what happened was the Department promised to give me clothing orders and they made me all kinds of promises. They never came to pass. It was just a continual struggle. You know, rent nowadays is $800 a month if you live in a decent neighborhood, unless you have low income housing. And with these kind of children, I needed to live in a house, you know, surrounding, and there was just several things that they needed. They needed special ed. The older girl was in special education and I, you know, there was just things that they needed help, professional help. They needed activities which we did not have transportation. You know.

Chairman **Miller**. Rhea, you work with—you are on the board of a program now, a child care——

Ms. **Perlman**. Child, Youth and Family Services.

Chairman **Miller**. One of the things that you pointed out that I think is important for people in policy positions, is that child care can be a tool that can be used to lessen some of our other problems.

Ms. **Perlman**. Yeah.

Chairman **Miller**. In terms of getting people to work. Obviously, Gilda is not going to be able to work if there is no child care.

Ms. **Perlman**. Right. And it should be something that everyone knows about automatically. You know, it is like—she should not have had to come about it by accident. You know, you have a kid, you have a child care spot. You know, it should be something that you can go just like a direct line. And it should be there for everybody so that there will be a lot less need for special services. I mean, it just makes sense to start with—the kids, even the kids that are healthy. If you start with the kids that are healthy, there are going to be a lot less sick adults later on because sick kids, you know—it just makes sense.

Chairman **Miller**. At the program we visited this morning, Para Los Ninos, several of the volunteers who were working there were saying that that was as much physical space as those kids would have all day long. That they would come there—one of the little kids comes at 6:30 in the morning and leaves at 4:00. But, after the program, they immediately go back to a hotel room. Because of the environment, they are obviously not going to be playing on the street or be playing in the neighborhood because that is just not available in terms of the mother's own maternal concern about the child. This is it, this is as good as it gets in terms of physical space.

I know, on our visits to welfare hotels in New York, we talked to family after family whose children were never allowed to leave the hotel room because of safety problems or because of drug dealers in the hall or violence in the hall or what have you. It is just hard to believe—to see how you get to the healthy development of a child in that environment. It is not going to happen.

Ms. **Perlman**. I agree. It is totally impossible. I thank God, at Para Los Ninos, that those kids have that space, you know. I was not there. I do not know how much space it was. I can imagine it was fairly little but some kids do not have that. Like you are saying, they are in the hotel room all day. Some kids are let out of the hotel room and they are wondering around the streets. You know, it is like six-of-one, I do not know which is worse. It is just a mess. And it is really preventable, I think.

Chairman **Miller**. Well——

Ms. **Perlman**. It is done in most other countries from what I have heard.

Chairman **Miller**. Yes, it is interesting. In the Congress, very often the argument is made that we cannot do this because this would be a drag on business and yet all of the countries that are supposedly beating our pants off in business competition, all provide these resources to their worker.

Ms. **Perlman**. It is not a drag on the business. I mean, from personal experience, I work at Paramount Studios and we set up a day care center about two years ago. I mean, Gulf & Western who is the corporation that owns Paramount was rather hesitant to do that but they were really pressured by people that they want to keep—they wanted to keep in the studios, to set it up. Once they did, I will tell you, it was just an instantaneous success. People were so proud of it. The employer—the employees, you know, people who worked there, were so happy to be working there, were so grateful to be working there, were at such peace of mind about where their kids were. It just increases productivity. It creates incredible good will. I mean, they find, in companies where they do not have child care, that people are on the phone all the time. They are distracted. They call in sick when actually they do not have a babysitter. It is just—they really need help and if a business can afford to help, they really should. If they cannot afford an onsite daycare center, then they can do other things in terms of subsidies and benefits.

Chairman **Miller**. Well, I think, you know, what we are seeing is a demographic trend, and this Committee spends a lot of time with the demographic changes in our Country. Some trends certainly seem to be permanent for the foreseeable future: Women are going to continue to participate in the work force. In fact, there is no chance to maintain economic growth without women in the work force, and they are going to continue to have children. Somehow, the tension that is then created out of economic necessity and out of raising a family is just starting to overwhelm an increasing number of families.

Ms. **Perlman**. Why does everybody not see that? Why are we having this hearing? You know, I do not understand where the conflict is. It is just so obvious.

Chairman **Miller**. Well, because to—I think to make those decisions and what the Committee has tried to do, and I think is starting to have some success, is to present évidence of effectiveness. Members of Congress really like venture capitalists. They think these are people who go out and they make large economic debts on the future of IBM or the future of Apple Computer at a time when nobody thought about that and they got big returns. Well, we are now able, I think, to show that this kind of up-front investment in children and families for the County government, for the Federal government makes economic sense. All of the evidence, whether it is evidence produced by the Select Committee or the Ford Foundation or the Reagan Administration, suggests real savings in making that investment. But, to get members of Congress to put the money up front so that we can see the benefits is still politically very difficult for people to do.

Ms. **Perlman**. I think that—what I think we need is for parents, before they get into terrible situations, you know, to get really vocal about this problem that they have. Parents do not talk out about it. They just do not feel like they can or they should or something. We really need an active parent organization. There is none. Like Mothers Against Drunk Driving, we need that for child care so they can lobby for it. Because we are not going to get it unless, you know, Congress is pressured to give it, unless bosses are pressured to give it. Why should they, you know. They really need—I mean, they should, but they are not going to. They really need people to be badgering them.

Chairman **Miller**. Well, we find also, then I want to let Mike ask some questions, that women are, in many instances, afraid to raise the issue.

Ms. **Perlman**. Yeah.

Chairman **Miller**. Because—even whether or not they have children. In our interviews and discussions, one corporation which now has a very extensive child care program, had never realized the number of women who worked there who have children because women thought that it was a threat to their job status. They thought that they would not be able to hold on and would not find advancement if the corporation thought that it was also going to have to absorb your concerns about your family. I just thing that you are almost getting to a point where failure to recognize these needs by corporations is almost becoming anti-family because that is the make-up of America's work force.

Ms. **Perlman**. Yes.

Chairman **Miller**. These are families with children and we should not suggest that that is the tradeoff that has to be made when we keep talking about the children being the future of the Country; no more children, no more future I guess would be the theory.

Ms. **Perlman**. I also was going to say one more thing. I do not think it is purely a woman's problem. I think that men, certainly my husband, is equally as concerned about the welfare of my kids as I am. And I find, you know, talking to fathers that they all are.

I do not think a father works as well or is at peace of mind at work if he does not think his kid is being taken care of and if the wife is out working, it is just as much his problem to find daycare for that kid, to make sure that kid is well taken care of. I hope—I do not know. Maybe it is just because I live in LA and it seems like businesses are being run now by people who are just having kids and I think maybe it is going to come into its own in that way; that there are more executives now who are just having kids and are really in a position to do something about it. And also, government leaders. I think that, you know, maybe that will help.

Chairman **Miller**. We have more and more members of Congress with their children in their laps.

Ms. **Perlman**. Yeah.

Chairman **Miller**. During and between sessions. Which is a testimony to the need for adequate daycare. No child should be exposed to that at an early age. [Laughter.]

Chairman **Miller**. Any questions? Well, thank you, very much because I think that your testimony this morning indicates the margin between having adequate care for your children and not having help, and what that means. You know, it can mean loss of a job, and so very often, public policy men do not understand what it means to operate at the margins on a daily basis, time after time after time. When you are trying to hold on, what a week in the hospital can mean whether you have child care or you do not have child care.

Bernesteen, I want you to know that we are, once again, undertaking a massive review in the Congress of the foster care system because we have just heard too many complaints from foster care parents and, as I said, the day before yesterday in Washington, we heard two marvelous articulations of the problems of the foster care system from young children who had spent most of their life in that system but somehow had learned to be very, very articulate. So, your concerns are being heard.

Rhea, thank you for your time.

Ms. **Perlman**. Thank you.

Chairman **Miller**. Thank you very much.

[Applause.]

Chairman **Miller**. The next panel will be made up of Wendy Lazarus, who is the Director of Southern California Child Health Network from Santa Monica; Xylina Bean, Doctor Xylina Bean who is the—I am not sure I am pronouncing it right, the Associate Clinical Professor of Pediatrics at UCLA; and Aja Lesh who is the Project Director of High Risk Infant Project Newborn Followup, California State University; Robert Chaffee who is the Director of the Department of Children's Services from Los Angeles; and Nancy Daly who is the Chairperson of the Los Angeles County Commission for Children's Services. Do we have enough places down there?

Welcome to the Committee. Your statements and the back-up documents and the evidence that you have provided will be placed in the record of this Committee in its entirety. The extent to which you can summarize will be appreciated and the extent to which you can give us your impressions and your suggestions about the problems that you are going to discuss will also be appreciated.

Wendy, we will start with you.

STATEMENT OF WENDY LAZARUS, DIRECTOR, SOUTHERN CALIFORNIA CHILD HEALTH NETWORK, SANTA MONICA, CA

Ms. LAZARUS. My name is Wendy Lazarus and I am the Director of the Southern California Child Health Network. We are part of a Statewide organization, the Children's Research Institute of California which has existed for 15 years. It is privately funded and a citizen voice for children.

On behalf of some of my colleagues in California, let me thank the Select Committee for your tireless work for five years straight. Tens of thousands of children have benefited here from your leadership in securing basic health care daycare, and income supports for them.

I am going to focus on the earliest and maybe the most potent intervention—early health care for pregnant women and babies. In this area, California is probably a bellwether for the Country. One out of every eight babies in the United States is born in California, and I think the challenges that we are facing here are the very ones that other states face, but they are writ much larger in California.

The bottom line is that we are on a downward slide in getting early preventive health care to pregnant women and babies. As a consequence, we are needlessly placing the lives of children at risk, and we are spending taxpayer dollars in a form that is really not as cost effective as we are capable of.

I want to cover very briefly, first of all, why this early health care is an opportunity; then, some of the disturbing trends that we are seeing now in California and in pockets across the nation. And finally, I'd like to suggest some policy suggestions from the Federal level that would assist us here.

We have just completed a six-month study of the health of mothers and babies in California. We would be happy to make our new "Back to Basics" report available to members of the Committee. In California, one out of every 13 babies is now born to a mother who received no prenatal care at all or received it so late that it really could not help; that is 36,000 women.

Lori is a baby who we got to know via her mother three years ago when she was unable to get prenatal care because she could not afford it. Lori was born three months early, weighing 2 pounds and 13 ounces. She had the typical problems that premature babies have and a hospital bill of $150,000. We have kept up with this family, and Lori who has just had her third birthday, is not yet walking. She needs physical therapy twice a week and has been diagnosed with cerebral palsy. Her mother's physician says that had she gotten prenatal care, the odds are very good that this could have been avoided and the premature delivery could have been avoided.

The surprising thing is that the services we are talking about are probably the best buy around. Prenatal care works because it detects and can often treat health problems that the mother has in her pregnancy that affect the baby. We are talking about contagious infections. We are talking about high blood pressure and risk of premature birth. A major demonstration project in California showed that the incidence of babies born at low birth weight was reduced by a third by getting moms early prenatal care and that the very low birth weight rates were reduced 40-fold.

The cost savings have been documented too. Just a couple of weeks ago, the Chairman of the California chapter of the American College of Obstetricians and Gynecologists said, in response to the "Back to Basics" report, "No intelligent investor would turn down such an opportunity." We have estimated that if California would provide prenatal care to the 36,000 women who do not receive it, the store could achieve, in the first year, a *net savings* of $30 million.

Let me tell you very briefly that California is missing the opportunity to get in there early and effectively. The health indicators from mothers and babies in our State are unfortunately worsening by every measure. And, California now ranks 36th among states because of our poor percent of pregnant women who are getting the early care they need. In terms of infant deaths California, the gap between black and white infant death rates is larger now than at any time in the 17 year history that such information has been collected.

Part of the explanation here is that we have more babies being born—about 20 percent more babies in 1986 than we had in 1980. In addition, more of the mothers are considered high risk, either because of their age or other factors which mean that their getting prenatal care is all the more essential. But currently in California maternity care is drifting further out of reach.

Our report documents this decline thoroughly so I will not give you all the particulars except to say that one out of every four pregnant women in California gets her health care while she is pregnant from our Medi-Cal program. But about 30 percent of those mothers live in counties in this State where there are so few Medi-Cal providers that care virtually does not exist. We have long, long waits at county clinics for women not on Medi-Cal who are relying on public clinics. This fact led the Chair of the California County Supervisors Association, Supervisor Barbara Shipnuck, to say, "In the past, county clinics have offered the last hope for many pregnant women but this hope has faded and no longer exists for a growing number of women in our State."

California has produced a few new studies which I summarized in my testimony. One shows that more of the working poor families in California have no health insurance. Financing is a major part of this problem. Eighty percent of the uninsured Californians are working parents and their children. I think that tells us something about where our priorities need to be.

Let me close by saying that, unlike some other more complicated fields of public policy, there is wide consensus about what needs to be done to get this earliest intervention to mothers and their babies. We have, thanks to Supervisor Antonovich and others on the County Board, taken some important steps in Los Angeles County. Last summer, the Board allocated an additional one million dollars to expand prenatal clinics and reduce the very, very long waits for women to get prenatal care appointments. County officials estimate and hope that the new funds will cut those waiting times in half. We are really very grateful for that important step.

At the State level, our Governor has proposed some increases in next year's budget for Medi-Cal reimbursement for obstetrics, and that, too, is a very important step. But, I think what is needed over the next few years is a continuing partnership between decisions made at the Federal, State and local level. Let me suggest four areas in which we need some help from the Federal level.

First, to make Medi-Cal coverage available to every needy pregnant woman. At a minimum all women whose family income is below the poverty level should be eligible for Medicaid. I understand that there is legislation to accomplish that in Congress now.

Secondly, we really need to look at our public programs—whether they be Medi-Cal or Maternal and Child Health—as businesses and institute sound business practices so the providers will want to participate in those programs. There are some initiatives at the Federal level, again, that could help on this.

Third, we know where many of the high risk women live and who they are. We need some targeted outreach and some real support services such as transportation, to get those women to the health care they need.

And finally, we need to build up the other related programs that have proved so effective as a companion to prenatal care. I am talking about the Maternal and Child Health Block Grant Program, the WIC Program, and Community and Migrant Health Centers.

Thank you so much for helping take the steps we have taken together, and we are eager to work with you to keep the progress going.

[Prepared statement of Wendy Lazarus follows:]

Prepared Statement of Wendy Lazarus, Director, Southern California Child Health Network, Santa Monica, CA

Chairman Miller and Members of the Select Committee

I am Wendy Lazarus, the Director of the Southern California Child Health Network. We are a project of the statewide Children's Research Institute of California, established 15 years ago to be a public voice for children. We are privately-funded, and are attempting to improve access to basic health services for California's children and families.

Thank you for coming to Los Angeles to learn about how we are doing at caring for high-risk infants and children and to discuss how we can all work together to do a more effective job. Thank you, too, for your tireless work on behalf of America's children over the past five years. Hundreds of thousands of children have been helped by your leadership in securing better health care, child care, and income supports.

Introduction and Background

My remarks will focus on the earliest and one of the most potent interventions--early health care for pregnant women and their babies. In this area, California is a bellweather for the country.

- One out of every eight babies born in the United States is born in California--nearly half a million babies each year.

- California's successes and its unmet challenges tell the story from other states, but they are writ larger here.

The bottom line is that we are on a downward slide in getting early preventive health care to pregnant women and babies. As a consequence, we are needlessly placing children's lives at risk of death and developmental problems, and we are spending more taxpayer dollars to provide remedial health care and family supports for problems that prenatal care and early intervention could have prevented.

A Project of the Children's Research Institute of California

I plan to address four areas: First, to explain in human terms what it means when women and their babies are unable to get the early intervention services they need; second, to set out, based on California's experience, why these early intervention services provide such an opportunity to help families and, at the same time, yield budget savings; third, to summarize several disturbing trends in California regarding the health outcomes of mothers and babies and their diminishing access to preventive care; and fourth, to suggest some policy directions to reverse these disturbing trends.

I will cover these points briefly because I am attaching to this testimony key findings from a report we issued three weeks ago about the health of California's mothers and babies. The full 120-page Back to Basics 1988 report provides extensive back-up for the points in this testimony and will be made available to members of the Select Committee.

Lori Is Typical of Young Children Whose Health Problems Could Have Been Prevented With Prenatal Care; The Human and Fiscal Costs Are High

The true story of Dorothy and her daughter, Lori, captures what it means to children and families when prenatal care is not available. Dorothy is not unusual--one out of every 13 pregnant women in California (36,000 women) now receives no prenatal care or receives it too late.

Dorothy-- a 33-year-old resident of Los Angeles County at the time she became pregnant with Lori-- could not afford to see a doctor early in her pregnancy. She worked part-time, and her husband was in school. When she had finally saved enough money to pay for prenatal care, she made an appointment. But one week before the day of her appointment, she went into premature labor. Lori was born three months early, weighing just 2 pounds, 13 ounces.

Lori had typical health problems that premature babies have. She had a collapsed lung, suffered a brain hemorrhage during birth, and needed heart surgery. The hospital bill for her neonatal intensive care came to nearly $150,000, which was paid by the publicly-supported California Children's Services and Medi-Cal programs.

Dorothy's physician told her that if she had received early prenatal care, Lori's health problems could have been avoided. Dorothy would have been found to be at risk for premature labor, and she would have been seen frequently by the doctor, and put to bed, or possibly given medication to prevent the very premature birth. She would have been alerted to the signs of early labor and advised what to do if it began. Once in labor, she would have had a doctor who knew her problematic pregnancy history, and could have been fully prepared to handle the delivery and any specialized care the baby needed.

Like other children born with preventable health problems, Lori's problems have persisted. Three years old in February 1988, she still cannot stand unaided. Her family has been told she has cerebral palsy. She goes for physical therapy twice each week. The profesionals working with Lori say there still may be some neurological problems that could slow her mental development.

Prenatal Care and Early Intervention Services Are Probably the "Best Buy" Around

Prenatal care works because it detects and can often treat health problems during pregnancy that affect the baby-- a contagious infection the mother has, high blood pressure, blood incompatabilities between the mother and baby, diabetes, and a host of other complications. A major demonstration project, conducted in 13 California counties during a recent three-year period, documented (as many other studies have) that prenatal care works. The so-called OB Access Program showed that comprehensive prenatal care:

- Reduced the incidence of low birthweight among babies (babies born weighing less than 5.5 pounds) by one-third.

- Reduced the percentage of babies born at very low birthweight (less than 3.3 pounds) by forty-fold.

- Saved $1.70 in the first year alone for every $1.00 invested in prenatal care. The savings are far greater when future costs of caring for disabled children with preventable health problems were taken into account.

As the Chairman of the California District of the American College of Obstetricians and Gynecologists recently stated in commenting on Back to Basics 1988:

> "A dollar spent in prenatal care today will save more than two dollars in less than a year. No intelligent investor would turn down such an opportunity."

The choices are clear; we can either spend the $1,200 needed to provide comprehensive prenatal care or $19,000-- the average cost of a sick newborn in a hospital intensive care unit whose health problems might have been averted altogether with proper prenatal care. Hospital bills for the sickest newborns often total $ 1 million.

We estimate that by providing prenatal care to the 36,000 pregnant women in California who go without it, the state would achieve a net savings of $30 million in the first year. The state would spend $43 million to provide care to these women and would save $73 million-- for a net savings of $30 million. This estimate of savings is extremely conservative because it does include the savings accrued after the child's first year of life-- from avoided special education and other services that parents here today will tell you more about.

California Is Missing the Opportunity to Provide This Earliest and Most Effective Form of Preventive Health Care

California, like many other places in the nation, is now reaching a smaller proporton of its pregnant women with prenatal care and is beginning to pay the price for this neglect.

---California's "Baby Barometers" Worsen

- According to the most recent comprehensive data (1985), the number and percentage of California's pregnant women who receive no prenatal care or who receive it too late is on the rise. This increase was experienced by Asians, Blacks, and Hispanics. Where more up-to-date information is available, the same disturbing trend holds. For instance, the University of California-San Diego Hospital reports a 31% increase between 1985 and 1987 in the number of mothers delivering their babies at the hospital having had no prenatal care at all.

- The percentage of babies born at low birthweight is also on the rise, with the preliminary statewide data for 1986 showing the percentage is higher in 1986 than in 1984.

- Infant death rates in California increased in 1985, the first such increase in 20 years. And while preliminary 1986 rates show that the overall infant mortality rate appears to have improved between 1985 and 1986, the gap between black and white infant death rates was wider in 1986 than at any time in the 17-year period tracked by the state.

---The Number of Babies Born Increases; More Are At High Risk

Approximately 482,000 babies were born in California in 1986--80,000 more babies than in 1980, representing an increase of 20%. Compounding this challenge is the fact that more women having babies in California are considered "high-risk"--either because of their age or because they are receiving inadequate prenatal care. Nearly one in five pregnant women is now "high-risk"-- a 14% increase between 1984 and 1986. The number would be even higher if there were accurate information on substance-abusing women and other high-risk groups that are difficult to identify.

--- Maternity Care Drifts Further Out of Reach

Access to publicly-funded prenatal care is growing more limited in California at the very time when more pregnant women need the services.

- One in four pregnant women relies on Medi-Cal for her health care during pregnancy. But obstetrical care is becoming hard and sometimes impossible for these women to find. In 29 of California's 58 counties, so few obstetricians take Medi-Cal patients that prenatal care is virtually unavailable for the 175,000 Medi-Cal eligible pregnant women of childbearing age who live in those counties--30% of all eligible women in California. The number of obstetricians and family practice physicians who take Medi-Cal pregnant women dropped between 1985 and 1986, while the number of Medi-Cal eligible women rose.

- For the working-poor pregnant women who do not qualify for Medi-Cal, prenatal care is also often nonexistant. Last year, Orange County prenatal clinics turned away 1,850 pregnant women, and clinics in San Diego turned away 5,000 needy women because these facilities could not handle the demand for services. In other counties, pregnant women must wait typically 4 weeks, and sometimes as long as 10 weeks, to get an appointment for prenatal care. Waits in Los Angeles County in 1987 were as long as 16 weeks.

- County clinics and hospitals are literally overwhelmed as more poor and uninsured pregnant women turn to these already overwhelmed facilities. In Los Angeles County, for example, the number of obstetrics claims submitted to Medi-Cal by the county nearly doubled. The President of the County Supervisors Association of California, Monterey Supervisor Barbara Shipnuck, says:

> "In the past, county clinics have offered the last hope for many pregnant women; but this hope has faded and no longer exists for a growing number of pregnant women... We still have a chance to turn the tide, shore up prenatal services throughout the state, and once again assure every baby in California gets off to a healthy start in life."

--- Increasing Numbers of Californians Can't Pay For Maternity Care and Have No Health Insurance

Several new studies make clear that families' inability to afford maternity care is a major reason why many needy pregnant women go without essential services. Researchers at UCLA recently interviewed the mothers delivering babies at the County/USC Womens' Hospital who received no prenatal care. The most frequent reason why these mothers went without care was "inability to pay." Well over half of the women who did not receive care had, in fact, tried to get services by the end of their second trimester of pregnancy.

A recent report about California's uninsured by a new organization called Health Access confirms that a growing number of families are unable to obtain the health care they need because they have no health insurance. As The California Dream, the California Nightmare reports, there are now 5.2 million Californians with no health insurance. Of these:

- Nearly 30% (1.5 million) are children.
- 80% are working parents and their children.

Another new study by the Institute of Health Policy Studies of the University of California at San Francisco found that 14% of the babies born in California were to mothers who had no health insurance-- either through Medi-Cal or private insurance. The majority of these 60,000 babies were born to families who typically could not afford the cost of maternity care. The group of uninsured women was composed, disproportionately, of Hispanic mothers and young mothers between the ages of 18 and 24.

It is clear that the lack of insurance and financial barriers in the form of fees keep women from care.

---This Neglect is Costly in Human and Fiscal Terms

A variety of indicators tell us that by neglecting this earliest form of health care for mothers and babies, we are paying a high price in human and fiscal terms.

- Nearly 39,000 California babies were in newborn intensive care units in 1986, a 17 percent increase from the previous year.
- While the number of live births in California grew by 20% from 1980 to 1986, the number of licensed beds in hospital newborn intensive care units grew by 60% (from 805 to 1,279).
- Expenditures in California's medical services program for handicapped children grew 10% last year. Program administrators report that the higher expenditures are due to an increase in infants who were born prematurely or at low birthweight and without adequate prenatal care.

- Medi-Cal paid an estimated $104 million for newborn intensive care in Fiscal Year 1986-87, an 80% increase in a three-year period.

These statistics are extremely telling. But they also leave out a very important message from the families who are affected-- for them, their baby's preventable handicap is a 100% matter, not an abstract statistic which may represent an increasing or decreasing percentage.

There Is Wide Consensus About Where To Go From Here

Unlike many other more controversial areas of children's policy, there is a great deal of consensus about the policy changes that should be made to ensure that every child gets off to the healthiest possible start in life. We, in California, are extremely fortunate to have leaders in Congress, our state Legislature, and on the Los Angeles County Board of Supervisors, who have gone to work to provide access to basic prenatal care and early intervention services for mothers and babies. Thanks to you and to them, the job is already underway.

For example last summer, the Los Angeles County Board, on the recommendation of Supervisor Edelman, voted to increase county funding for prenatal care by $1 million-- enough to reduce the waiting times for prenatal appointments by half and to see 25% more patients. The county has also decided to begin contracting with free and community clinics as a means of making care more available to needy women. In addition, the county is nearly ready to begin an information and referral line for pregnant women. These measures are making a very positive difference.

At the state level, although last year was a lean year for improving access to needed care, this year holds promise. Governor Deukmejian has proposed an increase in Medi-Cal funding for obstetrical care in the Fiscal 1988-89 budget, and the Legislature is considering nearly 20 bills and budget items related to perinatal care.

We thank you for your leadership at the federal level to expand prenatal care services. This partnership involving federal, state, and county initiatives needs to continue in order to deal effectively with the challenges. More specifically, we urge you to continue your work to:

- Expand Medicaid coverage for needy pregnant women. Expecting states to cover women with incomes below the federal poverty level is a sensible and cost-effective step forward.

- Institute sound business practices in Medicaid and in other public health programs capable of attracting and retaining providers in them.

- Target special outreach and community education efforts at high-risk groups--including Blacks, substance-abusing women, Hispanics, and teenagers.

- Build up the other programs that have proved their effectiveness for pregnant women and infants, including the Maternal and Child Health Block Grant, WIC, and Community and Migrant Health Centers.

We are eager to assist you in your work to get children off to the healthiest possible start in life. Please let us know how we can be helpful. Thank you.

Los Angeles Times

Wednesday, March 23, 1988

Total of Sick Newborns in State Rises as Prenatal Care Shrinks

By CLAIRE SPIEGEL, *Times Staff Writer*

More and more babies are being born sick or premature in California, as pregnant women face increasing difficulty in getting adequate medical attention, according to a private study released Tuesday.

A record $104 million in public funds was spent last year on hospitalization costs for these tiny infants, while many of their medical problems could have been prevented if their mothers had received adequate—and relatively inexpensive—medical care during pregnancy, the Southern California Child Health Network reported.

One promising sign, the group noted, is that the state's infant mortality rate resumed its downward trend in 1986, after a well-publicized increase during the previous year. However, director Wendy Lazarus pointed out that the gap in death rates for black and white babies in 1986 was wider than at any time in the last 16 years. Nearly twice as many black babies as white babies died during their first year of life.

Experts have concluded that prenatal care—consisting of between nine and 13 medical checkups of the mother beginning early in her pregnancy—significantly improves a baby's chances of being born healthy and surviving its first few months of life.

Yet access to this care has gotten worse. About one in 13 women in California get no prenatal care or get it too late, the report stated.

In 15 counties, the group reported, there were no obstetricians willing to provide prenatal care to pregnant women whose bills are reimbursed through Medi-Cal, the state's health insurance program for the poor. In Los Angeles County, as elsewhere, many obstetricians have discontinued treating Medi-Cal mothers, leaving one doctor for every 707 Medi-Cal mothers in Los Angeles County in 1986, according to the report.

Increasingly, women throughout the state are turning to overburdened public clinics for prenatal care, encountering long waits for appointments and being refused by the thousands in clinics in San Diego and Orange counties.

It was not uncommon for women to wait a month for appointments in San Bernardino, Alameda and Santa Cruz counties, the report noted. But lines were the longest last year in Los Angeles County, where women in some cases were forced to wait 16 weeks for appointments.

"I see firsthand the consequences of this," said Dr. Ezra Davidson, chief of obstetrics at Martin Luther King Jr./Drew Medical Center in Watts.

He said his statistics show that 28% of the 8,000 women who delivered babies at King last year had received no prenatal care, up from 20% the year before. Their babies, he said, accounted for half the newborn deaths.

Dr. Irv Silberman, director of maternal health and family planning programs for Los Angeles County, said he has no countywide data for 1987. But 1986 statistics "are markedly improved over 1985 and close to an all-time good record," he said.

Countywide, Silberman said, the number of women receiving inadequate prenatal care has dropped from 8.8% to 8.3%. Another good sign, he said, is that fewer babies in Los Angeles County are being born dangerously underweight.

However, across the state, 28,782 babies were born in 1986 weighing less than 5½ pounds, compared to 28,389 in 1985 and 26,538 in 1984.

The study prepared by the Child Health Network pointed out that for every $1 spent on prenatal care, the state could save at least $1.70 in hospitalization costs of children during their first year of life. Spending $43.2 million to provide prenatal care to the 36,000 women who each year go without it would yield a net savings of $30 million—and up to $345 million when future costs of caring for disabled children are taken into account.

Davidson illustrated the cost-savings potential by pointing to the case of 3-year-old Corina Guzman.

The toddler, who suffers from cerebral palsy, was born prematurely and weighing less than three pounds. Since birth, she has run up bills of about $200,000, which have been paid with public health dollars. But her premature birth might well have been avoided, doctors said, if her mother had received prenatal care. Her mother, Cinde Guzman, a free lance graphics artist, said she did not get prenatal care because she had no health insurance, could not qualify for Medi-Cal, and could not afford to pay $900 for doctors' care.

Leon Schwartz, director of the UC Irvine Medical Center, said the "Back to Basics" report by the Child Health Network makes clear that the state has two choices. "Either we can provide pregnant women with the preventive care they need, or we can pay a lot more later to treat babies whose problems could have been avoided."

Lazarus pointed out that some counties and community groups have taken steps to ease the prenatal care crisis but said that it will be up to the legislature and the governor to provide meaningful relief.

The County Supervisors Assn. of California has called for increased state funding of prenatal care programs. President Barbara Shipnuck of Monterey County pointed out that the state now spends $26 million a year to stock the state's waterways with fish and called for "that same level of investment in prenatal services."

RANKING CALIFORNIA'S NEWBORN DEATHS

HOW CALIFORNIA RANKS AMONG 50 STATES

	1970	1984	1985
Infant Mortality	7th	9th	14th
Newborn Deaths*	5th	15th	17th
Low Birthweight	12th	15th	17th
Late or No Prenatal Care	16th	34th	30th

* Deaths within 28 days of birth

RACE AND NEWBORN DEATHS (1985)

Newborn Deaths (Per 1,000 Births)	
All Californians	6.0
White	5.3
Black	10.6
Latino	5.6
Asian	4.2

Late/No Prenatal Care (Per 1,000 Births)	
All Californians	7.0
White	4.8
Black	10.8
Latino	9.3
Asian	6.2

Source: Back to Basics

Los Angeles Times
A Times Mirror Newspaper

Publishers
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Tuesday, March 29, 1988

The Dying Babies

This year nearly 4,500 babies will die in California before they are 1 year old. That's a dozen every single day of the year. Some of this tragedy could be prevented if babies' mothers had proper medical care while pregnant.

Instead of taking strides forward, California is falling behind by almost every measure of its performance. That was the view of Dr. Ezra Davidson, head of Drew Medical School's obstetrics department, in discussing a new report from the Southern California Child Health Network. In 1985, the last year for which complete statistics are available, 6 infants out of every 1,000 died before they were 28 days old; the year before, the figure was 5.9 per 1,000. Nearly twice as many black newborn babies as whites died.

The increase was small, and preliminary figures for 1986 show that the statewide rate has started to improve again. But the same 1986 figures show that more, not fewer, babies are being born weighing too little to thrive. That would be less likely to occur if more of their mothers were able to get good advice about nutrition and otherwise taking care of themselves while they're pregnant.

California used to do better. In 1970 California ranked fifth among the states in keeping newborn babies alive. Now it ranks 17th. This relates directly to prenatal care. California now ranks 36th in providing adequate medical care during pregnancy, down from 16th in 1970.

The statistics represent real babies who, when they do survive premature births, often face staggering physical and mental problems and require enormous investments in care. Lori, whose mother had not received prenatal care, was born three months early and suffered a brain hemorrhage and a collapsed lung. She had to have heart surgery. Now 3 years old, she may have cerebral palsy. She can't walk, and must have physical therapy three times a week.

The prescription for averting these tragedies is the same as it was at this time last year when the Child Health Network issued its first major report: Make sure that all women, regardless of income, receive adequate care during pregnancy. The Legislature voted last year to pay higher rates to doctors who see pregnant women under the Medi-Cal program, to keep physicians from dropping out of the program; Gov. George Deukmejian vetoed the bill. The Legislature also voted to pay doctors more if they would see women early and often during pregnancy; the governor vetoed that, too. The governor has proposed a 16% increase in Medi-Cal prenatal fees for doctors, starting in May, but that would bring their pay up to only $765 for the entire pregnancy, with an additional $150 if they agreed to provide comprehensive care. That is an improvement, but still far short of the funding needed to assure universal access.

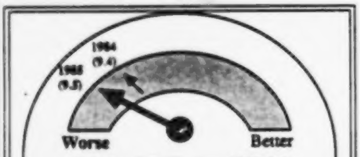
Many pieces of legislation addressing the needs of pregnant women and their babies have been introduced in Sacramento. One, by Assemblyman Burt Margolin (D-Los Angeles), would provide health care for all uninsured women as well as children under 5. More modest measures would ensure prenatal care for women whose family income is too high to qualify for subsidized programs but too low to enable them to buy private insurance, or who are excluded from state help because of their immigration status. One measure would change billing procedures in state health programs that deter doctors from providing care, and another would do away with eligibility rules that keep pregnant women from seeing doctors early in their pregnancy.

There are a few bright spots. Los Angeles County increased its own spending to improve prenatal care by $1 million last year, but many women still face long waits for appointments. Orange County increased the number of women whom it serves by 25%. "There is some momentum for change building," said Wendy Lazarus, the Child Health Network's director.

Clearly the progress is inadequate. Too many babies still are born unhealthy, and too many die as the Legislature and the governor postpone the providing of adequate funds for this extraordinarily cost-effective program.

CALIFORNIA'S PERFORMANCE ON EVERY BABY BAROMETER HAS WORSENED

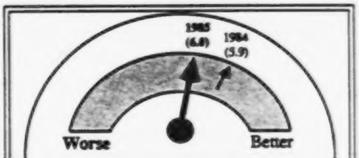
Barometer 1: California's Infant Mortality Rate



Rate for all Californians, 1985: 9.5
(per 1,000 live births)

Rates by Race, 1985
White: 9.1
Black: 16.2
Other: 6.4

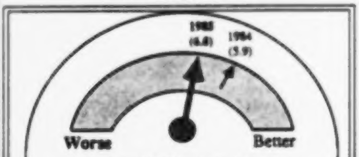
Barometer 2: California's Newborn Death Rate



Rate for all Californians, 1985: 6.0 (percent)

Rates by Race/Ethnic Group, 1985
White: 5.3
Hispanic: 5.6
Black: 10.6
Chinese, Japanese, Filipino: 4.2
Other: 6.0

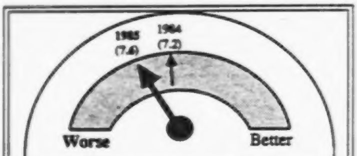
Barometer 3: California's Low Birthweight Rate



Rate for all Californians, 1985: 6.0
(per 1,000 live births)

Rates by Race/Ethnic Group, 1985
White: 5.3
Hispanic: 5.4
Black: 12.6
Chinese, Japanese, Filipino: 6.0
Other: 5.9

Barometer 4: California's Rate of Late or No Prenatal Care

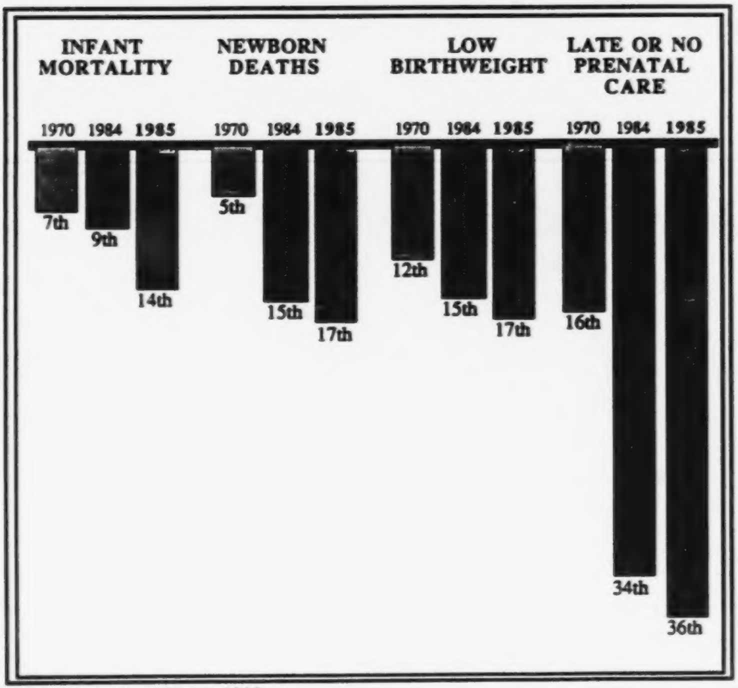


Rate for all Californians, 1985: 7.6 (percent)

Rates by Race/Ethnic Group, 1985
White: 4.8
Hispanic: 10.8
Black: 9.3
Chinese, Japanese, Filipino: 6.2
Other: 12.7

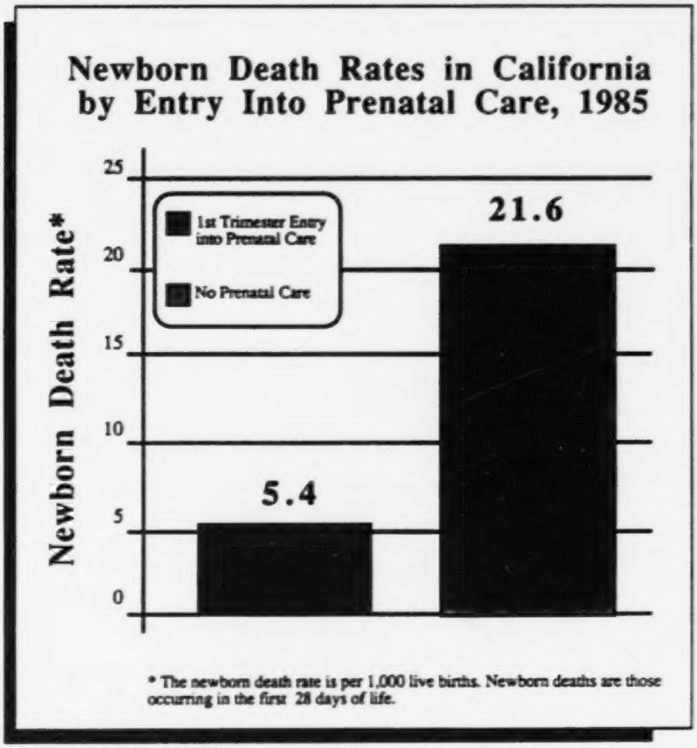
Source: *Back to Basics 1988*

California's Ranking Among States Has Dropped Dramatically According to Every Baby Barometer



Source: *Back to Basics 1988*

Prenatal Care Makes a Dramatic Difference in Reducing Newborn Deaths

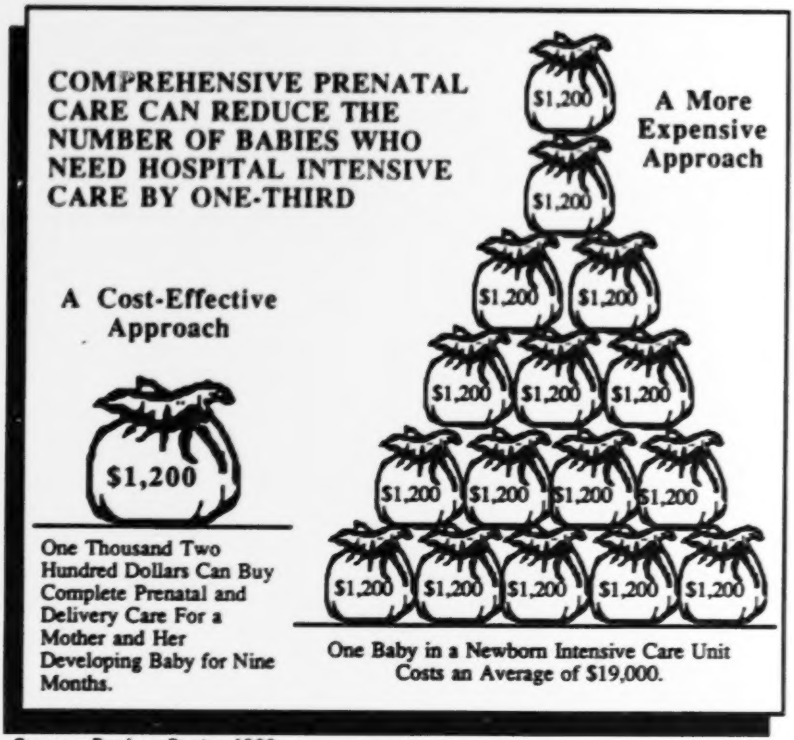


Newborn Death Rates in California by Entry Into Prenatal Care, 1985

* The newborn death rate is per 1,000 live births. Newborn deaths are those occurring in the first 28 days of life.

Source: *Back to Basics 1988*

California's Budget Choices



COMPREHENSIVE PRENATAL CARE CAN REDUCE THE NUMBER OF BABIES WHO NEED HOSPITAL INTENSIVE CARE BY ONE-THIRD

A Cost-Effective Approach
$1,200
A More Expensive Approach
$1,200

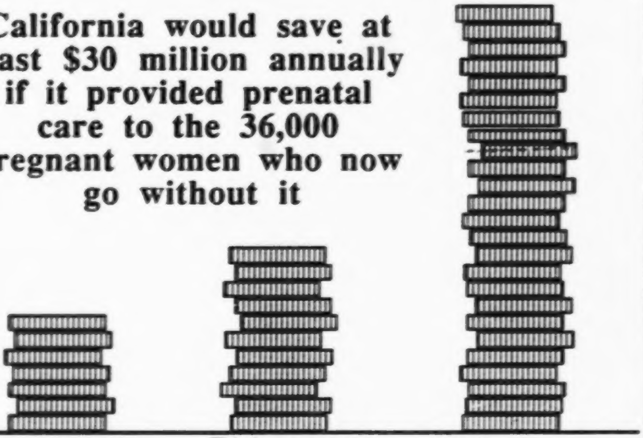
One Thousand Two Hundred Dollars Can Buy Complete Prenatal and Delivery Care For a Mother and Her Developing Baby for Nine Months.

One Baby in a Newborn Intensive Care Unit Costs an Average of $19,000.

Source: *Back to Basics 1988*

Investing In Prenatal Care Is Sound Economics

California would save at least $30 million annually if it provided prenatal care to the 36,000 pregnant women who now go without it



It costs $43.2 million to provide prenatal care to California's 36,000 unreached pregnant women.

This investment saves $73.4 million, with a **net savings** of $30.2 million in avoided hospital costs for children in their first year of life.

This investment nets savings up to $345.6 million when future costs of caring for disabled children are taken into account.

Net Savings =
$30.2 million to $345.6 million

Source: *Back to Basics 1988*

Chairman **Miller**. Thank you. Doctor Bean.

Dr. **Bean**. I need to correct one thing very quickly and that is that—or else I would be embarrassed forever all day, though I do have an appointment at UCLA Medical School, my primary work is at Martin Luther King, Jr. Hospital and Drew University which is in south central Los Angeles and not in Westwood. It makes a substantial difference.

Chairman **Miller**. Those of us from northern California do not know the difference.

STATEMENT OF XYLINA D. BEAN, M.D., ASSOCIATE PROFESSOR, PEDIATRICS, CHARLES R. DREW UNIVERSITY, DIRECTOR, INTERMEDIATE CARE NURSERY AND INFANT FOLLOW-UP PROGRAMS, MARTIN LUTHER KING, JR., GENERAL HOSPITAL, EXECUTIVE DIRECTOR, THE EDEN INFANT, CHILD AND FAMILY DEVELOPMENT CENTER, CO-CHAIR, THE COUNCIL ON PERINATAL SUBSTANCE ABUSE OF LOS ANGELES COUNTY, LOS ANGELES, CA

Dr. **Bean**. Thank you very much for inviting me to speak and I especially would like to thank Congressman Miller and also Supervisor Antonovich for allowing me to speak on this very important issue, young children in crisis.

The specific children in crisis that I want to bring to your attention this morning represent a new and growing group of high risk special needs children, children born to and cared for by women who are addicted to illegal drugs. There is no question that our society is currently experiencing an epidemic of addiction in both legal and illegal drugs, an epidemic which crosses all socio-economic, racial and gender lines. The dramatic increase of illegal drug use by women of child bearing age, both in California and the rest of the country has resulted in yet another drug victim, the fetus and newborn. In 1985, a study was conducted by the Perinatal Council on substance abuse in Los Angeles County which estimated that in Los Angeles alone, 60,000 women of child bearing age have drug abuse problems and that, at one time, approximately 17,000 pregnant women each year abuse drugs and/or alcohol during pregnancy. Pregnant drug abusers are at risk for multiple medical and obstetrical problems which result in major adverse affects upon pregnancy. These women are more likely to have stillbirths, premature infants and sick infants. In addition to the drug use itself, one of the major preventable contributing factors to the adverse pregnancy outcome in these women, is absence of prenatal care.

Since Wendy has already gone into that in extensive detail, the only thing I would like to do is reinforce that by talking a little about the problems we have at Martin Luther King General Hospital in south central Los Angeles. This is a largely minority, low-income population. We deliver about 8,000 babies per year. In 1981, the prenatal care rate of 10 percent was comparable to the national average. In 1987, this rate has increased to 23 percent and for 1988, it is projected that we will be delivering approximately 30 percent of our infants with no prenatal care.

Twenty percent of all our neonatal deaths at King are babies whose mothers did not receive prenatal care. Among babies identified at King as having had prenatal drug exposure, about 80 percent of these mothers have no prenatal care. A similar percentage of no prenatal care among substance abusing women is found at both Harvey-UCLA and LA County-USC, which together account for over one-third of all deliveries in Los Angeles County.

Another major problem besides the neonatal death clearly associated with inadequate prenatal care, is prematurity. Among drug abusing mothers the prematurity rate at our institution is close to 30 percent. It is about twice the national average. Though drug abuse itself is a contributing factor, with the assistance of the Los Angeles Drug Abuse Program office, prenatal programs specifically targeted for drug abusing women, run by Doctor Lynn Yonekura, formerly at LA County-USC, now at Harbor-UCLA, and Doctor Milton Lee and myself, at King-Drew, have shown that with good prenatal care, the mortality and prematurity rates in these women can be brought down very close to what we see in our regular population, which is still higher, of course, than the national average.

When you consider that in-hospital care for one premature infant ranges from $35,000 to $250,000, the provision of adequate prenatal care is one of the most cost effective interventions for this population. The exact number of babies in Los Angeles County born to drug using mothers is not known. These infants do undergo withdrawal when born and when these infants are identified as undergoing withdrawal, they are reported to the Department of Children's Services. Doctor Michael Durfee, who is Chief at the Child Abuse Prevention Program, has been collecting information on these infants when they are reported. In 1985, 543 infants were reported to his office. In 1986, this increased by 68 percent to 915 and in 1987, it is estimated that it will go up by another 34 percent resulting in a reporting rate, at this point, of close to 1,500 infants. seventy percent of these infants are born to mothers who use cocaine or crack, about 12 percent PCP, 8 percent opiates and 10 percent a variety of drugs.

In our institution, the incidents of these infants have increased from about 600 percent from 1981 when we identified about 50 infants to 1987 when we identified over 400 infants. Concurrently, a large percentage of reported cases of infants born with neonatal drug withdrawal do wind up being placed in foster homes. They, along with their siblings, find themselves in a variety of temporary placement, including emergency shelter care, group home, foster homes, institutions, and if they are lucky, with extended family members. Removing a child from its biological mother, as it was pointed out already by Congressman Miller, has far reaching and often, extremely negative consequence for subsequent maternal child bonding and on-going family structure.

Once separated from their mothers, many drug exposed infants live out their lives in multiple foster homes or institutions and never return to their biological families or become adopted. This often results in children with very poor self-esteem and no ability to develop appropriate social relationships.

Pregnancy and motherhood are strong motivating forces for women to become drug free. However, in Los Angeles, there is presently as long as a three-month waiting period for out-patient drug programs and an even longer waiting period for residential treatment programs. Very few women that I work with can remain drug free for three months before being able to start such a program.

Though still scanty, our knowledge, to date, on this population of high risk and special needs children, in terms of their long-term outcome, does indicate that these children are at extreme risks for long-term problems, especially with regard to school. Throughout long-term follow-up studies that we have done and also Doctor Judy Howard and Doctor Beckwith over at UCLA, all support the idea that these children are prone to school failure and in our society, school failure often equates with life failure.

Finally, in conclusion, I will mention two other problems that are peculiar to this population. One is the issue of alcohol abuse. Alcohol is one of the major alternative drugs, or additional drugs, that most of these women will use. And alcohol has clearly been shown to be detrimental to the developing brain. Infants who are exposed to alcohol have a much higher risk of having mental retardation and long-term problems.

And the final problem that I will mention is that of AIDS. Nationwide, 80 percent of pediatric AIDS is prenatally acquired and the majority of prenatally acquire AIDS is associated with women who are IV drug abusers or associated with IV drug abusers. Because of the nature of addiction, it is not possible to address this problem in this population by education alone. AIDS education must be linked with drug treatment if we are to have any effect in decreasing the incidents of pediatric AIDS and thus, saving the lives of these children.

In summary, infants born to drug abusing mothers represent a new and increasing number of high risk infants with many medical, legal and social problems that must be addressed. However, if there is to be any promise for tomorrow for these children, new ways of meeting their needs must be found. Specifically, more money and resources have to be directed towards drug treatment for these women as early as possible in pregnancy. And equally as important as financing foster care, more resources must be made available to maintain these infants within their own family.

[Prepared statement of Xylina D. Bean, M.D., follows:]

PREPARED STATEMENT OF XYLINA D. BEAN, M.D., ASSOCIATE PROFESSOR, PEDIATRICS, CHARLES R. DREW UNIVERSITY, DIRECTOR, INTERMEDIATE CARE NURSERY AND INFANT FOLLOW-UP PROGRAMS, MARTIN LUTHER KING, JR., GENERAL HOSPITAL, EXECUTIVE DIRECTOR, THE EDEN INFANT, CHILD AND FAMILY DEVELOPMENT CENTER, CO-CHAIR, THE COUNCIL ON PERINATAL SUBSTANCE ABUSE OF LOS ANGELES COUNTY, LOS ANGELES, CA

Thank you, Congressman Miller, for the invitation to testify before your Committee on the topic of "Young Children in Crises: Today's Problems, Tomorrow's Promises". As Co-Chair of The Council on Perinatal Substance Abuse of Los Angeles County, we are grateful to you for sponsoring this Hearing today, and to your staff for the excellent work they have done in organizing this important event. Thank you too, for including our County Supervisors and School Board Members as your colleagues in hearing our local concerns, so that our different levels of government and various agencies can act in concert to address the increasingly pressing needs of our infants and children. Because that's what it's going to take: concerted attention, genuine concern, and prompt action, to adequately address some of the "crises" facing our next generation.

The specific "children in crises" that I want to bring to your attention this morning represent a new and growing group of high risk, special needs children. I emphasize this fact, because as a neonatologist at The Martin Luther King Jr., County Hospital in south central Los Angeles for the past fifteen years, I have worked with thousands of high risk babies from birth through our infant follow-up clinics to school-age, but have never been so personally and professionally concerned and challenged as I now am regarding the increasing number of women who deliver at King without any prenatal care and the large number of infants who are born with prenatal exposure to drugs.

Since Wendy Lazarus from the Southern California Child Health Network has provided you with California's overall prenatal care picture in detail, in the interest of time, I only want to report that the number of women delivering at our hospital- which delivers about 7,000 babies per

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year - with no prenatal care rose from 10% to 21% between 1981 and 1987, and is projected to be 30% in 1988. Much of this increase has to do with the fact that many of the mothers we work with cannot get an appointment for prenatal care until after their expected date of delivery. Up to sixteen week waiting times have been reported to me by mothers seeking prenatal care appointments at County clinics as recently as this past winter.

That women are unable to receive comprehensive reproductive health care to help ensure the health of our next generation is not only morally wrong in a nation as privileged as ours, but it makes no sense in economic or manpower management terms. As the former associate director of the Neonatal Intensive Care Nursery (NICN) at King and director of the Intermediate Care Nursery, I can tell you that we use a lot of highly trained, very skilled, man and woman power hours and very expensive technologies to keep babies alive now that one year ago we would not have even tried to "salvage". Some babies do not make it despite our best efforts; 20% of all our neonatal deaths at MLK are babies whose mothers did not receive prenatal care. Those babies that we DO salvage are often discharged from the hospital with a "medically fragile" diagnosis - with a costly pricetag attached to their ongoing care - and at a very high monetary cost in terms of the in-hospital staff-to-patient ratio, length of stay, and medical and surgical procedures. The cost varies, but ranges from about $600 to $1,500 per day depending on the infant's diagnosis.

Because the medical profession is charged with saving lives, and is now increasingly charged with saving dollars, we do the best we can. Many babies that once would have required NICN admissions are now admitted to the Intermediate Nursery which has increased its technological capabilities. Frankly, however, treating problems that could have been prevented, as we are forced to do daily for example in caring for grossly premature neonates, represents mismanagement of our health budget and medical manpower since we know exactly how to avoid this "crisis" by provision of preventive prenatal services.

Among our highest risk populations, the wisdom of providing preventive health and social services is perhaps easiest to understand. Since I last presented testimony at Supervisor Edelman's Hearings on Perinatal Substance Abuse in Los Angeles in December 1984, the public at large has become aware of the fact that we are experiencing an epidemic of addiction of both legal and illegal drugs that crosses all socio-economic, racial, and gender lines. This epidemic is also rapidly crossing generational lines, with tragic consequences for our youngest citizens -- newborn babies -- who are born drug-exposed and often in withdrawal. Among babies identified at King as having had prenatal drug exposure, about 80% of their mothers had no prenatal care, with a similar percentage identified at the Harbor/ UCLA Medical Center in the South Bay Area.

Because of this very high percentage of substance abusing pregnant women with no prenatal care, three of the five County hospitals have each received $120,000/year from the County Drug Abuse Program Office (DAPO) to provide special social, psychological, and health services to augment the regular pre- and postnatal programs for this high risk population. Dr. Lynn Yonekura, Chair of Obstetrics and Director of this program at Harbor/UCLA, conducted a pilot "outcomes study" of mothers and babies involved in the program which demonstrated that even this small amount of funding made a significant difference in outcome health measures and proved to be a very cost effective method of providing services for this high risk population. (See Dr. Yonekura's written testimony for further details.)

Though the exact number of babies in Los Angeles County in 1987 who were born drug-exposed or in withdrawal has not yet been tabulated, the estimate is about 1,450 - 34% more than in 1986. This large number is unfortunately an undercount since only about 35% of the hospitals with maternity services actively participate in the County-wide reporting system organized by the Child Abuse Prevention Program under the direction of Dr. Michael Durfee. Nearly two-thirds of the babies in Los Angeles County who are identified as having prenatal drug exposure are delivered in County hospitals, with an increase of nearly 100% between 1985 and 1988 at Martin Luther King alone (representing more than 400 infants per year in recent years.)

Currently, a large percentage of reported cases of infants born with positive toxicologies are removed from their mother's custody at birth or placed under supervision of the Court or Department of Children's services because of interpretation of child abuse and endangerment laws. After discharge from the hospital and separation from their mothers, the infants, and very often, their siblings, are variously placed in emergency shelter care, group homes, foster homes, institutions, or with extended family members for varying amounts of time. Costs for these various placements range between about $525 to $3,000/month per child.

Though experience with this high risk population is historically limited, evidence to date has shown these infants and toddlers to be at high risk for: Sudden Infant Death Syndrome (SIDS), failure-to-thrive, increased susceptibility to colds and infections, poor state control, developmental delays, perceptual and behavioral disorders, visual, auditory, and speech disorders, poor motor coordination, disorganized social interactions, and an increased risk for HIV infections and AIDS. However, removing a special needs child from its biological family which usually has a greater interest in that child than anyone else, often has the inevitably far-reaching and often negative consequences for mother-child bonding and ongoing family structure. Once separated from their mothers, many drug-exposed infants are living out their lives in multiple foster care homes or institutions without ever being returned to their biologic families. Increasingly, prenatally drug-exposed infants and toddlers are perceived as "hard to place", "non-adoptable" children. This is especially true among the large number of such children who have never experienced a stable caregiving environment due to multiple placements in their first few years of life; in direct contrast to the intent of SB 14 - California's implementation of PL 96-272 - with which both Congressman Miller and Supervisor Edelman are so familiar.

Because we have now cared for more than 1,000 drug exposed newborns at King over the last eight years and have provided follow-up services to hundreds, I no longer believe, as I had once hoped, that the effects of prenatal drug exposure are time-limited. Preliminary data from a School Readiness pilot study we are conducting with 4 to 5 year olds who were exposed to at least PCP (the "drug of choice" at the time, though most substance abusing women delivering in L.A. County hospitals are poly-drug users with the current drug of choice being crack or cocaine), suggest that, in addition to their problems as infants, children who were prenatally drug exposed may be at risk for attention deficits, poor attachment, speech problems, proprioception difficulties, and acting out behaviors as they grow older. Other longitudinal follow-up studies underway in Los Angeles, under the direction of Drs. Judy Howard and Leila Beckwith at UCLA, are finding similar problems.

Though still scanty, our knowledge to date on this new population of high risk and special needs children indicates that the organic consequences of prenatal drug exposure pose a very real danger to California's next generation. An example of perhaps the greatest biologic threat to children of substance abusers is the risk of acquiring HIV infection and AIDS. Of the AIDS cases who are infants, nationwide 80% are acquired prenatally from the mother, with 75% of these having at least one parent who is an intravenous (IV) drug user. In Los Angeles County, about 50% of the cases of AIDS in children were prenatally acquired with maternal IV drug use being the primary source of infection. Because most infants who have prenatally acquired HIV infection currently die within the first year of life, it is not an overstatement to declare that birth itself is the death sentence for infants with prenatally acquired HIV infection.

As all studies to date have shown, education alone is not an effective method for altering high risk behaviors that lead to AIDS. Because of the unique psychological and biological problems of drug addicts, this fact is all the more true. Unless the educational and therapuetic programs directed to the substance abusing population of mothers addresses their drug dependency and its causes, we are unlikely to be able to stem the tide of this lethal disease in this high risk population and their offspring.

As a health professional committed to working with these high risk infants, children, and families, these sobering facts represent a challenge that myself and many dedicated colleagues have already begun to tackle. As policy makers and educators, I would like to challenge you on behalf of my colleagues, to allay a major concern of ours: That society's collective response, or lack thereof, to the issues surrounding perinatal substance abuse, may place these vulnerable infants and their mothers at even greater risk and pose an unprecedented threat to the fabric of our families.

In California and other states we have already seen the introduction of punitive legislation which seeks to criminally punish pregnant women for a variety of acts, or omission thereof, including not receiving timely prenatal care, not complying with their physician's "orders", using drugs during pregnancy etc.. Similar legislation has also been proposed to involuntarily commit or incarcerate pregnant substance-abusing women, rather than provide therapeutic programs to help them stop their self-destructive behaviors and become capable of competent parenting.

A punitive approach to this growing problem is inappropriate for many reasons, not the least of which is the fact that services designed to meet the special needs of this high risk population of infants and their families are virtually non-existent. Currently, "treatment" of drug-exposed newborns and their mothers in much of California consists of referring the mothers to drug treatment programs, removing the children from their custody, and referring the babies to high-risk infant tracking programs, with the latter referral only being made in systems where such programs exist.

This response is flawed at best, since it separates the mother from the infant, preventing rather than fostering maternal-infant attachment - which can provide an enormous motivation for women to become drug free -, and does nothing to enable the mother to become an adequate parent. It is even more flawed when the reality of the referrals is considered: the waiting time for even out-patient drug treatment programs in Los Angeles County is roughly three months. Residential (in-patient) treatment programs have longer waiting lists and only two residential programs accept substance-abusing women and their babies. Together these programs serve less than 30 cases/year depending on the attrition rate, and currently have no child development staff or parenting focus in their programs. No out-patient drug-treatment programs that accept women clients specifically provide information on the effects of substance abuse during pregnancy, or address their roles as mothers although several studies have shown that roughly 60% of women in treatment have children. This glaring omission in drug treatment programs is understandable only in the historical context since most drug treatment programs were designed to treat male substance abusers, and have infrequently modified their programs to address the unique problems of women, let alone the issues of substance abuse, pregnancy, and drug-exposed children.

Since in Los Angeles alone, we have collectively assumed responsibility for literally thousands of drug-exposed children by removing them from their biological families and placing them in a number of our social systems, ie: foster care, childrens'social services, juvenile dependency court, mandatory day care, public school programs, etc., it is incumbent upon us to review these children's progress within these systems to ensure that this course of action is, in fact, the best. Though no systematic study of these children's experiences in the various systems has yet been completed, anecdotal evidence from hundreds of cases with whom I have personally been involved, has led me and many of my colleagues to conclude that we must change our course of management to incorporate new information based on our eight years of experience with this population.

To that end, myself and several colleagues at the Drew University have established The EDEN Infant, Child, and Family Development Center, a therapeutic day-program of early developmental assistance for drug-exposed newborns and their families. Established in the Fall of 1987 in response to the need for appropriate child development and family services to meet the special needs of BOTH drug-exposed newborns AND their mothers, the overarching purpose of EDEN is to reduce the need for costly, inadequate, and ineffective out-of-home placement for drug-exposed newborns by providing:

- Home and Center-based developmental and care-taking services for drug-exposed newborns and siblings (age 0 to 3 at present time) who remain with their mothers,
- On-the-job, closely supervised parenting classes for their mothers at EDEN Center as a complement to drug treatment,
- Educational, referral, and support services to the extended family, at least two of whom must participate with the mother and child at EDEN, and
- Educational programs, workshops, and development of a model curriculum for other child care providers, community agencies, and educators working with this growing high-risk population.

EDEN currently operates on a shoe-string grant from the United Way of Los Angeles in the context of the philosophy of **habilitation, rehabilitation, and maintenance of the family**, with the focus on the infant AND mother (in keeping with SB 14), and **prevention** of:

- further family deterioration, (the presence of maternal substance abuse is considered evidence that some degree of family dysfunction and/or deterioration already exists),
- a maternal lifetime career of addiction, low self-esteem, and poor coping skills,
- additional drug-exposed newborns (in our eight years of experience at MLK, many women have rapid serial pregnancies - which result in the birth of another drug-exposed infant who is removed from the mother's custody),
- physical, psychological, and behavioral handicapping and/or debilitating experiences and conditions in the index newborn case and siblings.

The EDEN Center is currently serving 16 families (about 65 persons) and will serve 25 families when it reaches capacity within the next two months. Attached are several sheets which provide a broad-brush description of EDEN and its therapeutic goals which we hope will be useful to other programs and service providers working with this population.

You, as policy makers, can be very useful to us as care providers, by helping us to develop a mechanism whereby we can provide comprehensive and coordinated services to this high risk population. whereas many of the programs designed to address these problems are "categorical", the problems are decidedly not, and, in fact, must be tackled as a whole to have any lasting impact. Similarly, we must not only shift our funding and program mechanisms to be able to serve the multiple needs of one caregiver-child unit, but shift our way of thinking to enable us to serve the needs of parents and children TOGETHER.

Based on our experience, we know that the substance abusing pregnant and parenting women we serve at King, did not develop their drug dependencies overnight or in a social vacuum. Most of them have intergenerational experiences of addiction within their nuclear families; many of them had unstable environments as they were growing up; few of them looked to "tomorrow's promises" with anything other than dread or defensive apathy.

While the epidemic of perinatal substance abuse has not been around quite long enough for me to see one of "my" early identified "drug babies" delivering her own infant at King, I don't expect that day is very far away - and I wonder what we have to look forward to with our next generation of "today's problems". Will the drug-exposed infants that myself and my colleagues care for in the nursery be the broken members of tomorrow's society? - with no family, lack of love, low self-esteem?; tomorrow's drug dealers, addicts, gang members? Or does tomorrow hold a brighter promise for them? I believe that the answers to those questions are still open, and depend on the responses of all of us in this Board Room. Those of you who convened this Hearing can do much to make tomorrow a hopeful promise for our children in crises. Those attending can also do much by beginning with our own attitudes and responses to these high risk children and by influencing those of our fellow citizens. But, frankly, these intergenerational problems cannot wait for "tomorrow". Today's problems must be addressed today.

Thank you for your attention.

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THE EDEN INFANT, CHILD AND FAMILY DEVELOPMENT CENTER
A Program of Early Developmental Assistance
for Drug-Exposed Newborns and their Families

CENTER BASED PROGRAM

- Parenting Education
- Mother-Infant Counseling
- Individualized Treatment Plan: Infant, Mother, and Family
- Minimum Three Year Enrollment/Follow-Up
- Therapeutic Infant/Child Day Care
- Infant/Child Health Seminars
- Infant/Child Developmental Assessments
- Maternal Psychological Evaluation
- Individual & Group Counseling for Mothers
- Family Life Seminars
- Personal Health and Sexuality Seminars
- Assertiveness Training
- Home Management Seminars/Activities: Budgeting, Shopping, Gardening, Cooking, Fashion/Sewing
- Peer Group Support Network
- Extended Family Seminars/Activities
- Assistance in Interagency Case Management
- Referrals to Additional Services as Needed
- (Planned Service to be Implemented in Future: Warm Line)

HOME BASED PROGRAM

- Mother-Infant Counseling
- Implementation of New Parenting Skills
- Application of Home Management Skills
- Family Assessment and Individualized Treatment Plan Development with Mother and Family Input and Consensus

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THE EDEN INFANT, CHILD AND FAMILY DEVELOPMENT CENTER

A Program of Early Developmental Assistance
for Drug-Exposed Newborns and their Families

INTERAGENCY COLLABORATION

o Drug Treatment Programs

o King/Drew Medical Center: Pediatric and OB/Gyn Departments (and California Childrens Services (CCS), Special Supplemental Food Program for Women, Infants and Children (WIC), and the Child Health and Disability Prevention Program (CHDP))

o Department of Childrens Services (DCS)

o Compton Community College

o Foster Grandparents Association

o Rosa Parks Counseling Center

o Regional Center System

o Head Start Programs

o Public Schools

o Department of Public Social Services (DPSS)

o GAIN (Greater Avenues for Independence) "Work Fare" Program

THE EDEN INFANT, CHILD AND FAMILY DEVELOPMENT CENTER

A Program of Early Developmental Assistance
for Drug-Exposed Newborns and their Families

OBJECTIVES FOR MOTHER

- Become Active Participant in EDEN Center Program Components
- Become Drug Free
- Develop Self-Awareness, Self-Esteem, and Self-Direction
- Develop Parenting Skills
- Develop Life Management Skills
- Make Effective Use of Community Resources
- Obtain Appropriate Health Care Services for Herself and Infant/Child(ren)
- Provide a Safe, Nurturing Home Environment for Infant/Child(ren)

THE EDEN INFANT, CHILD AND FAMILY DEVELOPMENT CENTER

A Program of Early Developmental Assistance
for Drug-Exposed Newborns and their Families

OBJECTIVES FOR DRUG-EXPOSED INFANT/CHILD (& SIBLINGS)

- Experience Minimum Side Effects from Neonatal Drug Withdrawal
- Maintain Optimum Health During Infancy
- Develop Healthy Attachment to Mother
- Acquire Skills for Productive Play
- Develop Normal Cognitive, Communicative, Physical, and Social Skills, and, to the extent that this is not possible,
- Develop Compensatory Skills and Strategies As Needed
- Develop Spontaneous Appropriate Interactions with People, Objects, and Events in His/Her Environment

THE EDEN INFANT, CHILD AND FAMILY DEVELOPMENT CENTER

A Program of Early Developmental Assistance
for Drug-Exposed Newborns and their Families

OBJECTIVES FOR THE EDEN CENTER

- Provide a Safe, Therapeutic, and Nurturing Environment that Promotes Re-parenting of Mothers and Parenting of the Infants/Children
- Develop a Model Curriculum for Therapeutically Working with High-Risk Drug-Exposed Infants/Children, Their Mothers, and Families
- Facilitate Smooth Transitions for Mother/Infant/Child Units from EDEN Into Healthy Family and Community Activities
- Establish Sound Working Relationships with Local Resources and Agencies
- Disseminate Information About The EDEN Center, Its Findings, Experiences, and Program Results

Chairman. **Miller.** Thank you. Doctor Lesh.

STATEMENT OF AJA TULLENERS LESH, PROJECT DIRECTOR, HIGH RISK INFANT PROJECT NEWBORN FOLLOW-UP, CALIFORNIA STATE UNIVERSITY, LOS ANGELES, CA

Ms. **Lesh.** Well, we get the premature babies that Wendy Lazarus is talking about. We get the babies of moms that do not have prenatal care. I am head of a program that was started in 1979 to identify high risk infants and to provide in-home follow-up for these babies until they are two years of age. The focus of the project is to prevent developmental disabilities. We are now a program that deals with multi-risk families. We did not start out that way. Initially, our high risk criteria were designed to allow any baby that had only one of the criteria to be served, whether it was prematurity or drug withdrawal or a teen mom and so forth.

On the average, our babies have about 10 major medical problems during the neonatal period. The psycho-social environments are also extremely high risk and even the prenatal risk scores that we develop on our families include on the average, about 8. So, these are truly multi-risk families that we take care of. The biggest concern that I have right now is the number of babies that we are not serving. We identify and serve about one out of every four babies that are multi-risk and meet the criteria for services in our San Gabriel-Pomona Valley area and this has drastically increased over the past nine years.

The data that we would like to talk about just briefly is related to descriptive information about these high risk families. We started entering information on two years worth of follow-up and analyzing our results over time. One of the most critical things that we found is that about 50 percent of mothers who are already high risk based on a wide variety of reasons do not have adequate prenatal care. These 50 percent have late or non-existent prenatal care. 80 percent of our families have premature babies and the average stay in the hospital is 40 days which means, at about $1,000 a day per infant, that the County's, State's, or Federal government's initial investment in these babies is $40,000—if you just strictly go by hospital days. Our in-home services are about $1,000 a year per baby. When we looked at outcomes considering the numerous risk factors that these families have, it is exciting to realize that babies in the project were average or normal range for development and for growth at two years of age.

Now, often there is a lot of concern about, can intervention really make an impact? Can we make a difference in these families? My answer is yes! We can! And for a rather minimal up-front investment. It seems incredible to me that 75 percent of the high risk infants in the area are not being served. Particularly when you consider that these infants are also ones in which the government has invested $40,000, on the average, at birth.

I would like to briefly describe our findings in terms of what the families are like and then discuss the major early risk factors that we have identified and the impact that these risk factors continue to have at two years of age. Most of the babies that we have were less than 4 pounds at birth. 50 percent have low Apgar scores at birth. The average number of neonatal complications were 10 and these included heart murmurs, anemia, congenital anomalies, etc. About 50 percent of our babies have received blood transfusions. Close to 80 percent have respiratory distress and are ventilated. 82 percent have infections and are treated with antibiotics for more than 10 days. 78 percent develop jaundice and over 50 percent have nutritional or feeding problems in the hospital. So, these are difficult babies that are being sent home with lots of medical problems.

What kind of families are they being sent home to? 60 percent of our families are below poverty level, 53 percent are single moms, mostly unemployed, with less than a high school education. They take care of, on the average, between two and three children. The majority do not have insurance coverage and over 50 percent rely on Medi-Cal for coverage for their infants and children and for themselves.

There are some unique differences when we compared the high risk population with some national statistics for parents of newborns in 1983. Parents were comparable as to level of education, but they were twice as likely to be single, lack insurance coverage, and be living in poverty. The incidents of previous prematurity in this population was double the national average and, as I mentioned before, early prenatal care was received by about 50 percent, i.e. starting early in the first trimester. About 20 percent had no prenatal care or had maybe one visit prior to delivery. 19 percent of high risk mothers were teenagers and these statistic that really concerned me. What I did not realize, until I really started looking at these numbers, was that 92% of our teenage moms who also were abusing drug every single one of them except for one were in a physically abusive situation themselves. Teen mothers who abuse drugs are a particularly high risk group, one that we need to pay close attention to.

We also looked at alcohol use, medication use, drug use and smoking. Prenatally, we do not do a good job of identifying moms that are drug users; only about 50 percent of our substance abusing mothers are identified prenatally. The remaining 50 percent we identify following in-home intervention and more involved contact with the family. There are a number of reasons for this. Most babies do not show withdrawal symptoms until later following hospital discharge. Asking the mother whether or not she is taking drugs is not very effective. Few give accurate information and the incidence reporting on this is highly suspect as well.

When we looked, and Doctor Bean mentioned the concern about alcohol, when we looked at alcohol, we found alterations in both weight and head circumference at two years of age that were highly correlated with alcohol use prenatally. I think that there is a profound effect associated with alcohol use that continues on beyond the prenatal period.

When we looked at ethnic breakdown, most of our families were white, black, and hispanic—40 percent were white, 40 percent were hispanic and a little less than 20 percent were black. One of the things that follow-up of high risk infants traditionally has difficulty with is maintaining contact. Because we are predominately in-home based, I thought we might have less difficulty maintaining follow-up of families that tend to move around a lot. What I found out when I compared our results was that, the most significant finding, in terms of maintaining close follow-up, was that we were in the home within five days following hospital discharge of that baby. That was the only variable that came up significant and I think it really points to again, what Doctor Bean said, that pregnancy and delivery may be a particularly sensitive and important period for providing early intervention.

In relation to the differences between the various ethnic groups in being able to provide resources for their families, there is just one point I want to make. More data, or more information, is contained in the written testimony. Our Hispanic or Latino mothers are twice as likely to not have adequate funding for both medical care for her baby following delivery and for herself prenatally. 17 percent of our Latino mothers had no identified source of medical care for herself or for her baby compared to 4% in the white or black population.

When we looked at long-term follow-up, contrary to what most people believe, it was not how sick the baby was at birth that determined how well that baby did at two years. In every single measure that we looked at, both in relation to growth and in relation to development, it was the mother's relationship with that baby at birth that became one of the most significant predictors of how that baby did at two years of age—I cannot emphasize enough that programs need to be directed at the mother as well as at the baby. We have to emphasize the importance of the relationship between mother and child from the very beginning. It is a mistake to focus programs only on children and not incorporate the mothers' needs as well. The mother's feelings about the infant was related to both head circumference growth and weight not as much for length and for all measures of development as well.

The group that I would consider at greatest risk at this point in time, and we follow about 650 families over the years, are mothers who are severely depressed. What we find is that mothers who are severely depressed fail to adequately nourish and interact with their babies. This results in babies that are failure to thrive. I have included a growth curve which mirrors depressive episodes in the mother with a plateau in growth in the baby of both weight and head circumference and I think it is really important to emphasize that this is brain growth that we are talking about. Each depressive episode in the mother is mirrored in the growth curve on the baby. This was a normal term infant that was at the 50th percentile at birth who is now below the 5th percentile at 6 months of age. She has since been hospitalized both for a severe apnea episode for which no related cause has been identified and also for dehydration. This is clearly a failure to thrive baby that started out as a normal healthy term infant. Again, this is to re-emphasize the point that that relationship between mother and baby is a particularly critical one, one that we need to emphasize and pay attention to.

Secondly, there are several measures that attempt to identify how the mother interacts with the baby, and how well she is able to provide developmental resources for her baby, i.e. how focused she is on development. When we first started out, these particular measures of the home environment were 10 points below average.

When we ended at two years, they were at the average level and this was true even though the severely psycho-social high risk situations for these families did not change. They were still living in difficult situations. They still had no transportation. They still had difficulties getting medical care, poverty, frequent arguments, and other, what I would consider, high psycho-social risk factors. It is important to emphasize that the results of the study indicate that even within significantly high risk situations, that the mother can invest and pay attention to her baby. She can become totally committed to that baby's well-being and the baby can develop normally. That it is an extremely important finding.

Finally, I would like to read just briefly from a letter that one of our moms wrote. I asked her to just put down her reactions to the services. I will just read a portion of what she said:

> If the service had been two dollars, I would not have been able to afford it. I was in a bad way emotionally, worried about my baby. I thought I was going to lose her. Then to have someone come out to your home to see your baby, helps you tremendously. I would have broken down at least twice, I am certain, without the project. Having a sick baby is nothing short of overwhelming devastation. A sick baby can change your life dramatically. Economically, you can lose your car, even your house, because you cannot work. You have to take care of your child.
>
> I have a social worker and I have always gotten too little, too late. Oh, I survived during a critical period in my life where my baby was not well but it was the project that provided items of clothing for my baby, funds for toilet paper and soap and detergent to wash my diapers. The Center, or Project, arranged for my phone to stay on and told me where to go to get free food and formula if I needed it. It is difficult to put all this into words how much it (the project) means to me.
>
> Both baby, and mother and father need this program. My baby is doing fine now and a large part is because I am doing fine. I would not be doing fine if it was not for the project and I am truly grateful.

Thank you.

[Prepared statement of Aja Tulleners Lesh follows:]

PREPARED STATEMENT OF AJA TULLENERS LESH, R.N., PH.D., PROJECT DIRECTOR, HIGH RISK INFANT PROJECT NEWBORN FOLLOWUP, CALIFORNIA STATE UNIVERSITY, LOS ANGELES, CA

EARLY INDICATORS OF GROWTH AND DEVELOPMENTAL OUTCOMES IN HIGH RISK INFANTS: IMPLICATIONS FOR SOCIAL POLICY

Description of the Project

The Newborn Follow-Up Project (MCH Grant, State Department of Health Services) at California State University is an multi-discipline, in-home intervention program that has provided services to approximately 650 infants in the San Gabriel/Pomona Valley area of Los Angeles County since 1979. Infants are identified in hospital by the hospital liaison nurse and referred prior to hospital discharge (see Appendix A for referral criteria and assessment schedule). Professionals providing home support services are predominantly nurses and educators with consultation from nutritionist, occupational therapist, social worker, and psychologist. Interventions are family focused and emphasize nutrition, medical care, protection from environmental hazards, development of a close attachment with the primary caregiver, and opportunities for infants to practice appropriate developmental skills, and emotional support for the family.

Introduction to the Study

This study focused on assessing the influence of biolcgical and environmental variables on the growth and development of high risk infants who participated in an intervention program. Of particular interest was the degree to which initial risk variables are able to predict infant growth and development at 2 years. Three hundred thirty-five infants, designated to be at risk for developmental delays at birth between 1979 and 1984, were utilized to develop extensive risk indices measuring perinatal, neonatal, and psychosocial factors. In addition, the home environment and the mother-infant relationship following hospital discharge were assessed.

Infants and families were considered to be multi-risk based on an average of 25 risk factors per infant/family. Greenspan (1987) has documented that just 4 risk factors in a family can result in cognitive delays for infants. Comparison between the sample and California's high risk infant population in 1986, indicate striking similarities. Findings in the study may, therefore, have implications for the larger at risk infant population.

What are the infants like?

Infants are transported to various neonatal intensive care units (NICUs) based on severity of complication and beds available. Forty different hospitals referred infants for services. Hospital distance represented a significant hardship, particularly to low income families who were often unable to arrange for transportation to see their sick infants. Many had only infrequent contact with their babies prior to home-coming. Hospital stay ranged from 1 to 237 days with the 40 being the average number of hospitalized days.

Infants were considered to be severely high risk based on multiple medical indicators in addition to prolonged hospitalization. The majority of infants were premature (81%) with the average infant being delivered 2 months early. The weight ranged from 620 (less than 1 1/2 pounds) to 5727 grams (average weight was less than 4 pounds at birth). Along with their premature births, 50% had low Apgar scores at birth indicating some time of fetal distress during labor and delivery.

Number of prenatal complications per infant were 8. The number of medical complication during the first month of life averaged 10 per baby with 29 being the highest number received. Medical risk factors most commonly identified were apnea (breathing difficulties), heart murmurs, anemia and blood transfusions, respiratory distress, infections, jaundice, nutritional and feeding problems (see Tables 1 and 2 for frequency of medical risks).

High risk infants in the study experienced extended hospitalization and separation from parents, and a wide range of medical problems and treatments prior to going home. Their first few months are uniquely different from other infants. Normal term babies are sent home after one to two days hospitalization with no medical problems identified. All infants in the Project were considered to be at increased risk for abuse/neglect based on prolonged separation at birth, the special needs of the infant, and family/environmental circumstances.

Description of the families

The majority of families referred to the Project are young, low income families who often do not have the financial, educational, and emotional resources to cope with becoming a parent, let alone the parent of a high risk infant. The poverty threshold for a family of four in 1983 was $10,178 (Winard & Rudolph, 1985). Sixty percent of the families were at or below poverty level, 53% were single women, mostly unemployed, less than a high school education, responsible for an average of 2 to 3 children. The majority did not have insurance coverage and close to 50% relied on MediCal to meet the cost of pregnancy and delivery. Regardless of income 2/3 of the families experienced severe financial difficulties following the birth of their high risk infant. When women in the study were complared with national statistics for parents of newborns in 1983, they were comparable on levels of education, but were twice as likely to be single, lack insurance coverage, and be living in poverty (Table 3)

The incidence of previous prematurity was double the national average. Prenatal care was less available with 49% starting prenatal care early (compared to 75% nationally) and with 20% receiving extremely late or no prenatal care (5% nationally). Age is considered a risk factor as well, and 19% of the mothers were below 19 years of age. A number of other risk factors are influenced by behaviors which are somewhat under the mother's control (Table 4). These include prenatal care, medications, drug use, alcohol use, and smoking. Incidence of smoking (21.5%) and drinking (39.2%) are comparable to 1980 national statistics. It is important to emphasize that in subsequent analyses, alcohol use by the mother during pregancy was significantly correlated with both low weight and smaller head circumference at two years of age.

Identified drug use was 8.1% prenatally. After extended contact with families the actual incidence was closer to 20%. It is the researchers perception that substance abuse is significantly underreported prenatally. Drug use was significantly correlated with abusive family situations, with depressed mothers, poverty, lack of prenatal care, and with high psychosocial risk scores. Ninety-two percent (92%) of the teenage mothers who were using drugs were living in physically abusive environments.

The majority of mothers had 8 to 9 psychosocial risk factors identified with 27 being the highest number received (Table 5). Environments often lacked basic necessities. Mothers were frequenly isolated (40%) with no transportation (19%), living in extremely difficult and often unsafe environments (33%), experiencing financial difficulties (62%) and frequent illness and health problems in family members (25%) and herself (18%).

Comparison of High Risk Families based on Ethnicity

Ethnic breakdown for families in the Project was as follows, white (40%), Latino (40%), Black (14%), Asian (3%), and other (3%). Comparisons were made between the three largest groups based on history of previous pregnancies, prenatal risk factors, and infant outcomes at birth. Group differences were found between ethnic groups only on environmental factors and prenatal care. All infants in the Project had multiple risk factors at birth and difficult neonatal course. But the environment into which these infants are discharged from the hospital are different on a number of significant factors that have implications for the family's ability to mobilize resources for their infants.

If an infant goes home to a white family, chances are about 75% that the mother is a high school graduate, has a partner that works full time, and a family income (64%) over $12,000 per year. Only 4% of the mothers and infants are not covered by either insurance or MediCal. An infant discharged to a black family has about a 50% chance that the mother has graduated from high school, has a partner that works full time, but their annual income falls below $8,000. Most infants and mothers are covered by MediCal with only 4% having no medical coverage. For a latino family with a high risk infant, chances are less than 40% that the mother has graduated from high school. She hs a 70% chance that her partner works full time, by for 60% the family income falls below $8,000 annually. More importantly, 17% of the infants and mothers having no identified medical coverage. There were women in all ethnic groups that received no prenatal care, but in the high risk population a latino mother has more than double the chance of receiving no prenatal care when compared to other mothers (Table 6).

Growth, health, and development at 2 years

A subset of 139 infants, for whom longitudinal data was available, was analyzed in greater depth at 24 months. Although the lack of a control group severely limits the ability to evaluate the intervention program, one of the most impressive findings in the study was that infants who were identified as muli-risk at birth and participated in a two-year in-home intervention program, were basically healthy and within the average range of growth and development. Given the severity of risk factors at birth, babies were performing at their adjusted age (for prematurity) on all measures of development except language (Table 7). Most had caught up to their peers in weight and head circumference (Table 8). This is in spite of the fact that many continued to have health problems during the first year and 42% experienced at least one repeat hospitalization prior to their 2nd birthday (Table 9).

A number of statistical procedures were utilized to identify which factors at birth and later during follow-up are the best predictors of infant outcome at two years. This would allow us to refine early risk indicators and allocate resources to those who are at greatest risk. Contrary to what most people believe, inant development, growth, and health status at 2 years are not determined by how sick the baby was at birth. The best predictors of infant outcome at two years were early measures of the mother's relationship with her infant and home environment. This is not to imply that biomedical risks do not affect the infant, but to highlight the degree to which the environment can attenuate the impact of early medical problems. Conversely, biomedical risks can interact with environmental risk to significantly decrease the infant's development and growth.

The findings clearly illustrate that the infant's home environment and relationship with the mother are important influences on the child's growth, health and development. A simple example will illustrate the point. Appendix C contains a growth graph for a healthy term infant born to a teenage mother. The infant, who was at the 50th percentile for growth at birth, now at 6 months is below the 5th percentile. Repeat severely depressive episodes in the mother are mirrored in the infant's growth chart predominantly through lack of weight gain and brain growth. Following intervention an improvement in weight gain and head circumference is seen (second arrow) which levels off again following another depressive episode. Mothers who are severely depressed fail to adequately nourish and interact with their infants, resulting in infants who fail to thrive. One third of the infants in the sample had mothers who were identified as significantly depressed following the birth of their infant.

Several measures were used to evaluate the home environment including the HOME Inventory developed by Caldwell (1970). Scores on the HOME Inventory, particularly in the area of play materials, variety of daily stimulation, and mother's investment in development, showed a dramatic improvement of over the two year period (Table 10). Scores at birth were over 10 points below the average. By two years of age scores on the home enviroment were within average range. The indication is that even within significantly high risk living situations and with severely ill and difficult infants, mothers in an intervention program were able to invest time and resources in their infants and achieved average growth and development.

Implications for policy and practice

Policy decisions regarding the predominant use of biomedical factors as risk indicators at birth may need to be reevaluated, and parent-infant relationships and home environment emphasized both in risk assessment and intervention. The traditional emphasis on only designated infants at risk if medically fragile or premature is contrary to most research findings including this study.

Flexibility of exit and entry into the "at risk" category at various ages also needs to be explored with emphasis on delaying early diagnosis, providing interventions based on risk assessment, and reevaluating at one year. Mothers' perceptions of their infants may be influenced by early diagnosis of abnormalities and could potentially be a self fulfilling prophecy. Awareness of the importance of the mother's relationship with her infant on developmental outcome coupled with the fact that early evaluations following birth are not predictive of later development (Table 11) indicates extreme caution in using early diagnosis. Later measures of health, growth, and development are much better indicators of infant outcome than the earlier measures. By twelve months the trend is clearly established. Developmental scores, weight, and head circumference at 12 months are powerful predictors of outcomes at two years.

This study, consistent with other research, indicates that early intervention may have a significant influence on growth and development at two years. At a minimum, the cost to society per infant was $40,000 based strictly on the average number of days hospitalized. The Project provides in-home follow-up and intervention services at approximately $1,000 per year per infant. With the large initial investment already in place and the potential for even greater costs in special education and other programs, it appears to be cost effective to invest in prevention oriented programs.

It also appears that the intervention process should be directed as much at the mother as the infant. The importance of the mother-infant relationship in shaping infant outcome continues to be emphasized in the findings. Interventions can have a profound impact on the ability of the mother to meet her infant's needs in ways that cannot be clearly measured. As one single mother so poignantly stated,

> ...Having a sick baby is nothing short of overwhelming devastation...A sick baby can change your life dramatically. Economically you can lose your car even your house, because you can't work. You have to take care of your child....If the services had been $2.00, I could not have afforded....
> (See letter by parent, Appendix D)

APPENDIX A

SELECTION CRITERIA

One condition from Column A or three conditions from Column B.

A	B
1. Birthweight 1500 grams or less	1. Neonatal drug addiction
2. Required assisted ventilation for longer than 40 hours during the first 20 days	2. Mother has a developmental disability
3. Had sustained hypoxemia, acidemia, hypoglycemia, or repetitive apnea	3. Maternal age below 18 or over 35
4. Evidence of intracranial hemorrhage	4. Poor maternal/infant attachment as determined by hospital staff
5. Seizure activity during the first week of life	5. Maternal education equal to or less than 10th grade
6. Small for gestational age	6. Failure to thrive infant
7. Congenital anomalies	7. Home environment lacking stimulation
8. Hyperbilirubinemia	

APPENDIX A

MEASURES FOR VARIABLES BY TEST PERIOD

Variables	Evaluation Period						
Independent Variables	Discharge	1 Mos	3 Mos	6 Mos	12 Mos	18 Mos	24 Mos
A. Variables - Initial Risk Status							
1) Length of Hospitalization	X						
2) Gestational Age	X						
3) Weight for Gestational Age	X						
4) Apgar Scores (1 and 5 mn)	X						
5) Growth Parameters	X(birth)						
6) Maternal Obstetrical History	X						
7) Prenatal Risk Score	X						
8) Neonatal Risk Score	X						
9) Psychosocial Risk Inventory		X					
B. Demographic Variables							
1) Age		X					
2) Ethnicity		X					
3) Education		X					
4) Employment		X					
5) Occupation		X					
6) Income		X					
7) Financial Source of Care	X						
8) Individuals in Household		X					
9) Number of Rooms in Household		X					
10) Primary Caregiver	X						
11) Marital Status	X						
Dependent Variables							
C. Assessments							
1) Parent/Infant Interaction		X					
2) Physical Evaluation of Infant			X	X	X		X
3) Primitive Reflex Evaluation			X	X	X		
4) Language Evaluation						X	
5) Developmental Evaluation			X	X	X		X
6) Home Inventory			X	X	X		X
7) Infant Health Status			X	X	X		X
8) Growth Parameters			X	X	X		X
9) Psychosocial Risk Inventory					X		X

APPENDIX B (TABLES 1 TO 11)

TABLE 1

INFANT CHARACTERISTICS

Variables	#	%
Sex (N=335)		
male	191	57.0
female	144	43.0
Number of Days Hospitalized (N=329)		
less than 15 days	71	21.6
15 to 30 days	96	29.2
31 to 60 days	97	29.4
61 to 90 days	46	14.0
91 days or more	19	5.8
Gestational Age (N=329)		
25 to 29 weeks (severely premature)	50	15.0
30 to 37 weeks (premature)	229	70.0
38 to 44 weeks (term)	50	15.0
Weight for Gestational Age (N=328)		
SGA (small for gestational ag	61	18.6
AGA (appropriate for gestational age)	249	75.9
LGA (large for gestational age)	18	5.5
Birth Weight (N=333)		
below 800 grams	11	3.3
801 to 1500 grams	119	35.7
1501 to 2500 grams	135	40.5
2501 to 5000 grams (normal range)	66	19.8
5001 grams and greater	2	.6
Birth Length (N=246)		
27.49 cm and below	-	-
27.5 to 37.49 cm	33	13.4
37.5 to 47.49 cm	158	64.2
47.5 to 57.49 cm (normal range)	53	21.5
57.5 cm and greater	2	.8
Head Circumference (N=213)		
25.49 cm and below	11	5.2
25.5 to 31.49 cm	127	59.6
31.5 to 37.49 cm (normal range)	72	33.8
37.5 cm and greater	3	1.4
Apgar Scores at 1 minute (N=293)		
0 - 3	64	21.8
4 - 6	92	31.4
7 - 10	137	46.8
Apgar Scores at 5 minutes (N=298)		
0 - 3	15	5.0
4 - 6	49	16.5
7 - 10	234	78.5

TABLE 2

FREQUENCY TABLE OF NEONATAL RISK FACTORS IN HIGH RISK INFANTS

N=328 Presence of high risk factors occurring in more than 5 percent of the sample.

Factor	frequency	percentage
Blood disorders	31	10.0
anemia	84	27.1
transfusions	144	47.1
Cardiac Difficulties		
bradycardia	148	47.7
heart murmurs/anomalies	103	33.1
hypotension	28	9.1
patent ductus arteriosus (PDA)	76	24.5
persistent fetal circulation	22	7.1
Congenital Anomalies (other than cardiac)	48	14.6
Infections	75	24.3
antibiotics	251	79.9
sepsis	52	16.8
Jaundice	245	78.0
Metabolic Disorders		
hypocalcemia	85	27.6
hypoglycemia	59	19.1
hyponatremia	52	16.8
acid/base disturbances	80	25.8
Neurological Abnormalities		
abnormal EEG	18	5.5
abnormal reflexes	20	7.1
hypotonia	27	8.7
intraventricular hemorrhage (IVH)	36	11.6
seizures	40	12.9
tremors/jittery	26	8.4
Nutritional/Feeding Problems	165	52.7
necrotizing enterocolitis (NEC)	17	5.2
Respiratory Distress	237	73.8
asphyxia	96	30.7
apnea	154	49.4
atelectasis	32	10.4
bronchopulmonary dysplasia	54	17.3
hypoxic episodes	59	19.0
meconium aspiration	15	5.0
pneumothorax	27	8.7
transient tachypnea	58	18.8
ventilator assistance	147	47.0
Visual Problems	37	12.1

TABLE 3

SOCIOECONOMIC VARIABLES OF FAMILIES OF HIGH RISK INFANTS

	#	%
Mother's Education		
none	3	1.0
8th grade or less	34	11.0
9-12th grade	97	31.5
graduated from high school	108	35.1
some college	46	14.9
graduated from college	20	6.5
Father's Education		
none	6	2.3
8th grade or less	30	11.3
9-12th grade	69	26.0
graduated from high school	98	37.0
some college	35	13.2
graduated from college	27	10.2
Single Mothers	151	53.0
Income (yearly)		
$4000 or less	37	14.8
$4001 to $8000	65	26.0
$8001 to $12000	40	16.0
$12001 to $16000	25	10.0
$16001 or more	83	33.2
Source of Income		
both parents	49	15.8
one only	143	46.0
family support	19	6.1
public support	91	29.2
none	9	2.9
Father's Employment		
full time	189	69.7
part time	22	8.2
at home/not employed	60	22.1
Mother's Employment		
full time	22	7.3
part time	19	6.2
at home/not employed	262	86.5
Delivery and Hospital Costs		
Medical	141	45.0
Private Insurance	129	42.0
Other	40	13.0
Financial Stress		
yes	191	67.0
no	93	33.0

TABLE 4

PRENATAL RISK FACTORS UNDER MOTHER'S CONTROL

Variable	frequency	percentage
Medications (N=260)		
no	101	35.6
yes	183	64.4
Presence of medications occurring in more than 5% of the sample		
Analgesics	16	6.2
Antibiotics	36	13.8
Anticonvulsants	29	11.2
Antihistamines	16	6.2
Antipyretics	26	10.0
Hormones	13	5.0
Labor Inhibitors	28	10.8
Drinking (N=298)		
none	203	68.1
occasional	85	28.5
1 drink daily	2	.7
more than 1 drink daily	8 (4 susp.)	2.7 (1.3)
Smoking (N=306)		
none	205	67.0
1 pack or less per day	74	24.0
more than 1 pack per day	27	8.8
Illegal Drug Use (N=310)		
no	271	87.4
yes	25 (14 susp.)	8.1 (4.5)
Substances identified as being used during pregnancy*		
Marijuana	6	
Methadone	4	
Heroin	7	
Cocaine	6	
PCP	4	
Other	7	
Prenatal Care (N=306)		
Care was begun in		
1st trimester	149	48.7
2nd trimester	95	31.0
3rd trimester	35	11.5
none	27	8.8
Use of Prenatal Vitamins		
no	134	51.1
yes	128	48.9

*Information on illegal substance use is difficult to obtain and generally underreported.

TABLE 5

FREQUENCY TABLE OF PSYCHOSOCIAL RISK FACTORS IN HIGH RISK INFANTS

	Presence of high risk factor	
Factor (scored on Caregiver)	frequency	percentage*
Relationship with Infant (8 items)		
Mixed feelings, lots of reservations (mother)	70	22.6
Mixed feelings, lots of reservations (father)	68	30.6
Foster parent or relative caretaker	28	8.8
Does not feel infant belongs to her	37	11.7
Lacks confidence in ability to care for infant	45	14.1
Expectations are developmentally inappropriate	114	37.3
Displeased with appearance/behavior	111	35.7
Lack of privacy for mother and infant	102	33.8
Support/Resources (7 items)		
Separated, divorced, alone	72	23.5
Help with infant care (less than needed, none)	112	37.5
Emotional support (less than needed, none)	150	51.0
Isolated, few or no friends	118	40.5
Medical care is inadequate and/or not available	55	17.8
Reluctant to accept advice/guidance	120	38.2
Difficulty utilizing resources	95	28.4
Environment (9 items)		
Family has been victimized by crime	20	6.4
Child Protective Services involved	58	18.4
Home environment unsafe/neglected	75	24.6
Home environment disruptive/crowded	83	26.9
Basic utilities not present	16	5.1
No phone	48	15.1
No transportation	56	19.1
Frequently displaced, no place to live	56	18.2
Overall living situation is inadequate/difficult	102	32.5

TABLE 5 , continued

	Presence of high risk factor	
Factor (scored on Caregiver)	frequency	percentage*
Relationships with Others (7 items)		
No eye contact, avoidance	52	16.3
Disorganized, no routines	45	15.4
Depressed	86 (12 susp.)	28.0 (3.9)
Emotional abuse of mother	41 (12 susp.)	13.9 (4.1)
Frequent arguments and conflicts	127	43.5
Physical abuse in family	27 (26 susp.)	9.0 (5.6)
Substance abuse in family	34 (26 susp.)	11.3 (8.6)
Family Stresses (8 items)		
Father unable to find work	43	18.4
Mother returned to work, looking for a job	71	22.4
Income dependent on family, state	119	38.3
Financial difficulties, large debts	175	61.6
Family members with chronic illness	27	8.8
Recent loss or death	22	7.1
Chronic or frequent illness of mother	54	17.5
Emotional or physical problems with siblings	54	17.5

*Stated percentages may change for a given frequency based on sample size.

TABLE 6

COMPARISON OF SOCIOECONOMIC MEASURES WITH ETHNICITY

	White N=127	Black N=44	Latino N=132
Mother's Education			
none	-	-	2
8th grade or less	3	2	23
9-12th grade	23	42	38
graduated from high school	44	34	26
some college	20	22	9
graduated from college	10	-	2
Father's Education			
none	-	3	5
8th grade or less	7	0	22
9-12th grade	19	36	34
graduated from high school	44	37	28
some college	15	18	10
graduated from college	15	6	1
Income (yearly)			
$4000 or less	11	19	20
$4001 to $8000	10	33	41
$8001 to 12000	15	19	18
$12001 to $16000	12	11	7
$16001 or more	52	18	14
Father's Employment			
full time	73	49	70
part time	10	9	6
at home/not employed	17	42	24
Single Mothers	36	75	51
Teenage Mothers	11	23	24
Delivery and Hospital Costs			
Medical	35	71	50
Private Insurance	61	25	33
Other (cash)	4	4	17
Prenatal Care			
1st trimester	53	52	40
2nd trimester	31	30	32
3rd trimester	10	11	16
none	5	7	12

TABLE 7

COMPARISON OF VARIABLES MEASURING DEVELOPMENTAL STATUS WITH AGE APPROPRIATE SCORES

Developmental Variables	12 Months Mean	24 Months Mean
	(n=116)	(n=112)
Fine Motor	22.7	39.0
age appropriate score*	(22-23)	(38-39)
Cognitive	69.6	83.8
age appropriate score	(69-70)	(84-85)
Language	112.8	127.9
age appropriate score	(111-112)	(129-130)
Social	155.5	167.0
age appropriate score	(154-155)	(165-166)
Gross Motor	286.6	287.6
age appropriate score	(269-271)	(286-288)

*Age appropriate scores are scores consistent with 12 and 24 month level abilities based on the Michigan-Schafer Developmental Profile.

TABLE 8

COMPARISON OF GROWTH PARAMETERS WITH NATIONAL AVERAGES

	12 Months		24 Months	
Growth Parameters	Sample Mean	National Center* Mean	Sample Mean	National Center* Mean
MALES (n=76)				
Weight	9.6 (25%)*	10.2 (50%)	12.4 (50%)	12.6 (50%)
Length	74.4 (25%)	76.0 (50%)	85.5 (25%)	88.0 (50%)
Head Circum.	46.6 (40%)	47.0 (50%)	49.0 (50%)	49.2 (50%)
FEMALES (n=63)				
Weight	8.9 (25%)	9.6 (50%)	11.9 (50%)	11.90 (50%)
Length	73.0 (25%)	74.0 (50%)	83.6 (25%)	86.5 (50%)
Head Circum.	45.6 (45%)	45.7 (50%)	47.9 (50%)	48.0 (50%)

*Percentiles and national means are based on growth curves and rankings developed by the National Center for Health Statistics.

TABLE 9

FREQUENCY TABLE OF DEPENDENT VARIABLES MEASURING INFANT HEALTH STATUS
(n=139)

	24 Months	
Health Variables	Frequency	Percentage
Health Status		
major multiple medical problems	8	5.8%
single major medical problem	16	11.5%
minor health concerns	60	43.2%
healthy	55	39.5%
Medications		
none	64	46.0%
1st year only	65	46.1%
2 years	11	7.9%
Medical Visits (2 years)		
Illnesses		
none	9	7.3%
less than 5	60	48.3%
5 to 10	41	33.1%
11 to 20	11	8.1%
21 or more	4	3.2%
Well Baby checks		
none	1	0.8%
less than 5	24	19.5%
5 to 10	63	57.7%
more than 10	27	22.0%
Hospitalizations (2 years)		
none	79	58.1%
one	31	22.8%
two	11	8.1%
three to six	12	9.0%
more than six	3	2.0%
Immunizations		
current	93	70.0%
not current	40	30.0%

TABLE 10

TRENDS IN HOME ENVIRONMENT AND PSYCHOSOCIAL SCORES OVER TIME

	Mean Scores			
Variables	Initial	6 Mo	12 Mo	24 Mo
HOME (Total Score)	27.8	33.8	36.3	38.1
Emotional Responsivity of Mother	8.5	9.7	9.9	10.1
Avoidance of Restriction and Punishment	6.3	6.4	6.1	6.2
Organization of Environment	4.2	5.2	5.3	5.5
Provision of Appropriate Play Materials	3.3	5.5	6.9	7.7
Maternal Involvement with Child	3.6	4.6	4.8	4.7
Opportunities for Variety in Daily Stimulation	1.8	1.0	3.2	3.7
Psychosocial Risk (Total Score)	7.5		6.8	6.1
Relationship with Infant	1.6		1.3	1.3
Support/Resources	2.1		2.1	2.0
Environment	1.2		1.0	.8
Relationship with Others	1.2		1.0	.9
Family Stress	1.7		1.5	1.3

TABLE 11

CORRELATION MATRIX INDICATING TRENDS IN INDEPENDENT AND DEPENDENT VARIABLES OVER TIME

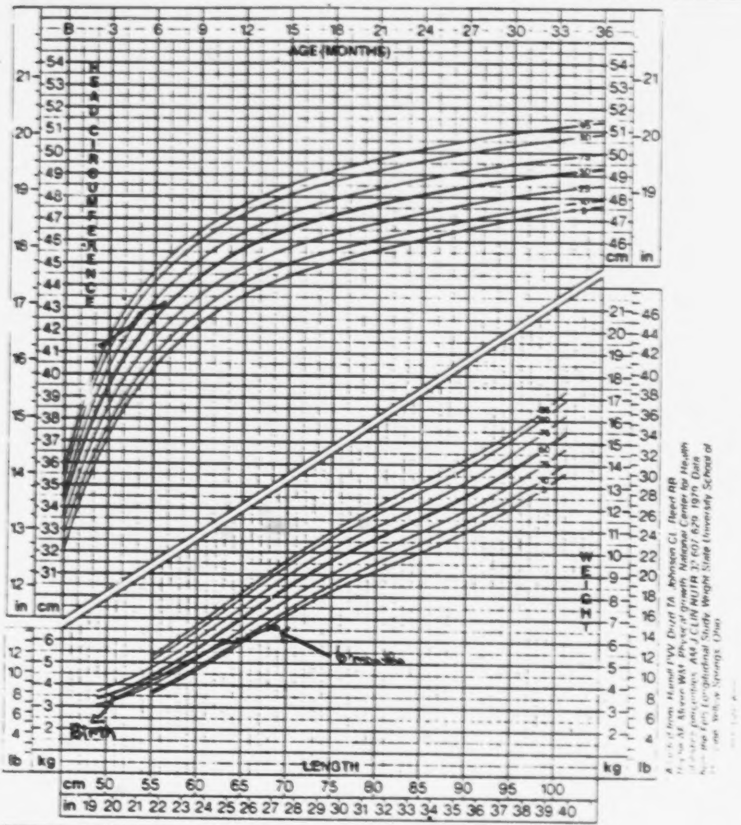
Dependent Variable at 24 Months	Time Period in Months			
	Birth	3 Mo	6 Mo	12 Mo
GROWTH PARAMETERS				
Weight	.26**	.51**	.67**	.74**
Length	.28*	.32**	.41**	.42**
Head Circumference	.35**	.59**	.63**	.77**
DEVELOPMENT				
Fine Motor Development		.13	.25*	.27*
Cognitive Development		.04	.25*	.35**
Language Development		.05	.27*	.44**
Social Development		.09	.20*	.23*
Gross Motor Development		.25*	.34**	.50**
HEALTH STATUS				
Rehospitalizations	.35** (Initial #days)	.18* (# of hospitalizations)	.39**	.73**
Number of sick visits		.27*	.40**	.60**
Medications		.41**	.36**	.34**
Number of well baby visits		.19*	.16*	.19*
Immunizations current		.20*	.03	.24*
Independent Variable at 24 Months				
HOME Inventory		.32**	.47**	.71**
Psychosocial Risk Score	.64**			.75**

*Significant at .05 or less.
**Significant at .001 or less.

GIRLS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES*

APPENDIX C

NAME ______________________ RECORD # ____________



*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Longitudinal Study, Wright State University School of Medicine, Yellow Springs, Ohio.

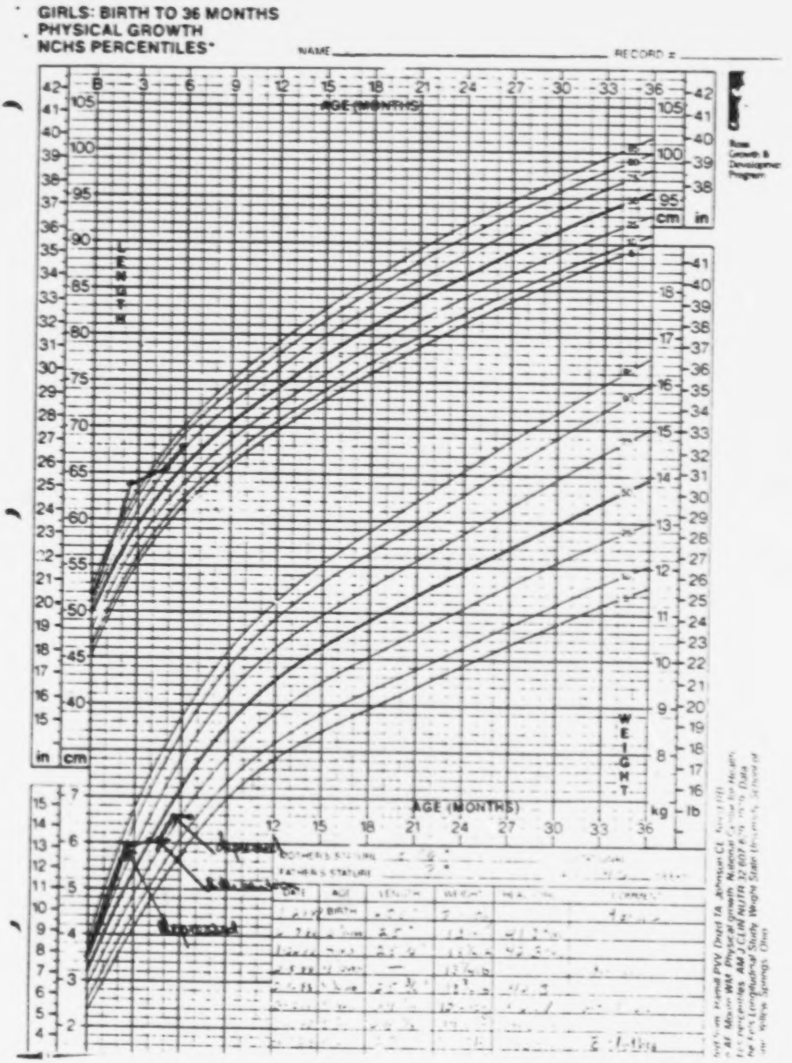
DATE	AGE	LENGTH	WEIGHT	HEAD CIRC	COMMENT

SIMILAC: Infant Formulas
in vivo performance
closest to mother's milk

ISOMIL: Soy Protein Formulas
When the baby can't take milk

ADVANCE: Nutritional Beverage With Iron
Instead of 2% lowfat milk

ROSS LABORATORIES


GIRLS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES*
NAME
RECORD #
AGE (MONTHS)
LENGTH
WEIGHT
in
cm
kg
lb
Ross Growth & Development Program
MOTHER'S STATURE
FATHER'S STATURE
DATE
AGE
LENGTH
WEIGHT
BIRTH
Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607
Fels Longitudinal Study, Wright State University School of Medicine, Yellow Springs, Ohio

September 14, [illegible]

APPENDIX D

My name is [illegible] Johnson. My daughter [illegible]
was born premature with "respiratory complications"
and apnea, a tendency to stop breathing. As a
mother I found it very important to have a
compassionate qualified person to talk to. One
available and willing to help. I have a [illegible]
good doctor, but I don't always have time to
ask all of my questions and can't interrupt
him. I'm always able to call the Newborn
Follow-up Center, without feeling [illegible] that way.
I have a social worker and have always gotten
a little too late. Oh, I survived during a
critical point in my life when my baby was
not well, but it was the Center that provided
items of clothing for my baby, funds for [illegible]
and soap, and detergent to wash my diapers.
Center arranged for my phone to stay on, and
told me where to go to get free food and form-
if I needed it. It's difficult to put into words
how much the Center means to me. I'm just
grateful to God to have the Center available
to me. If the service had been $2.00, I would
not have been able to afford it. I was in [illegible]

[illegible]

I thought I was going to lose her. Then to have someone come out to see your baby helps you up on the progress more often than the doctor and eases the worry. I would have broken down at least twice, I'm certain, without the Center.

My particular nurse Aja is a Godsend. She encouraged me to get County aid when pride was a big obstacle. She's full of information from baby stools to sibling rivalry, and support groups to talk to other parents to help or be helped.

Raising a sick baby is nothing short of overwhelming to irritation. I can see where well babies don't need the Center. Everything goes back to normal after 3 or 4 months. A sick baby can change your life dramatically. Economically, you can lose your car, even your house, because you can't work. You have to take care of your child.

Both baby and mother/father need this program. My baby is doing fine now, and a large part is because I'm doing fine. I would not be fine if it weren't for the Center and Aja. I am truly grateful.

Dallas Johnson

Chairman **Miller**. Thank you. Mr Chaffee.

STATEMENT OF ROBERT L. CHAFFEE, DIRECTOR, DEPARTMENT OF CHILDREN'S SERVICES, COUNTY OF LOS ANGELES, LOS ANGELES, CA

Mr. **Chaffee**. I am Robert Chaffee, Director of the Los Angeles County Department of Children's Services. My Department is responsible for carrying out Title IV-B, Child Welfare Services and Title IV-E, Foster Care Maintenance payments and Adoption Assistance programs initiated by Public Law 96-272. My full testimony is already on file with the Committee but today, I would just like to——

[Pause to repair microphone.]

Mr. **Chaffee**. Well, let me start again on a high note of saying good morning Congressman Dreier, Congressman Miller, Supervisor Antonovich. I am Bob Chaffee, Director of the Los Angeles County Department of Childrens Services. My Department is responsible for carrying out Title IV-B, Child Welfare Services and Title IV-E, Foster Care Maintenance payments and Adoption Assistance programs initiated by Public Law 96-272.

My full testimony is on file but this morning I would like to emphasize the need for a broad range of pre-placement preventative services to maintain children in their own homes and to facilitate early re-unification. I also would like to talk about the increased severity of abused and neglected children coming into the Child Welfare system and their impact on our ability to recruit and train foster homes. And also, the need to better prepare our older foster children for emancipation and productive adulthood through expanding the independent living initiative.

As this Committee knows, the most important child welfare legislation in the last 20 years was very likely Public Law 96-272. Los Angeles County actively worked for passage and still continues to fully support its philosophy on families and children. The State legislation to implement Public Law 96-272, SB-14, specified a variety of pre-placement prevention and family reunification services: These were counseling, parent training, for example, respite care, in-home temporary caretaker, teaching and demonstrating homemaker and transportation. I think we already are on a different plateau today because despite these expectations, there has never been really sufficient funding in California or anywhere else to my knowledge in the Country, to provide the full range of these services. To get some idea of the scope of the problem and the high expectation that is required for services being given to children, let us look at some of the numbers of children served in Los Angeles County. One out of every 30 children in the nation lives in Los Angeles County. The Department serves 45,000 abused and neglected children at any point in time. We have 29,000 children that are juvenile court dependents and 23,000 that are in out-of-home care and more than 15,000 children are taken into protective custody in the last year alone. Now, many children must be removed from their homes due to imminent danger of severe neglect or abuse. However, many are removed because there are no other service options. For example, children who are chronically neglected, seriously emotionally disturbed, substance abusers, medically fragile and infants harmed by prenatal exposure to drugs and alcohol.

In-home and community based resources could enable parents, or extended family, to cope with problems and maintain family unity. In addition to the pre-placement prevention services mandated by Public Law 96–272, and SB–14, the following home and community based services are needed to keep families together, certainly child care treatment for substance abusers, day treatment and extended day socialization programs for emotionally disturbed and conduct disordered children, household management, intensive in-home support programs such as Family Builders, and in-home health care services for medically fragile children including AIDS victims. With a full range of support services as described, the goals of P.L. 96–272 to keep children at home could finally be realized.

My recommendation is that the Federal government must take a leadership role and assume a greater share of costs by funding Title IV–B of the Social Security Act at a level which will cover costs of all essential pre-placement prevention and family reunification services.

Now, the foster care issues in our program, for example, in Los Angeles County alone, referrals are increasing in severity as well as numbers. Some of the statistics are there has been a 61 percent increase in sexual abuse petitions between 1981 and 1987. A 500 percent increase in Juvenile Court petitions alleged excessive prenatal drug use between 1981 and 1987 and an 1100 percent increase in Juvenile Court petitions alleging drug ingestion by child or infant suffering drug withdrawal between 1981 and 1987. Unfortunately, the number of foster home beds has not kept pace with the increased demand for placement. There is an extreme shortage of foster home beds for infants and toddlers, teen mothers and their babies and for children with special needs. For example, emotionally disturbed children, medically fragile children, infants prenatally exposed to drugs.

There really needs to be, in our area, recommendations for foster care, a greater emphasis on the use of home of relatives in keeping with the philosophy of Public Law 96–272, a need to increase recruitment efforts with emphasis on foster parents willing to accept special needs children. We need intensive initial instruction and on-going on-the-job training for both relatives and foster parents to develop the child care knowledge and skills required to care for special needs children and we need adequate compensation to retain both relative and foster home placements. The constant demands for caring for very needy children exhaust relatives and foster parents both physically and emotionally and much needed support services for them include respite care to provide relief for foster parents and relatives, counseling services for the foster family to enable them to cope with family changes or stresses caused by the entry of foster children into the home, day treatment and extended day socialization programs for emotionally disturbed children, in-home health care services for medically fragile children, around-the-clock crisis intervention for foster parents caring for mentally ill or severely emotionally disturbed children.

Some children, of course, need the structure and supervision that only a residential treatment setting can provide and we value these facilities and greatly appreciate the efforts our local group home providers have made in the last few years to develop intensive treatment programs for our most needy children. However, additional foster homes are needed to reduce use of these more costly facilities in order to accept children who could be maintained in family homes if support services were provided and to receive children who have completed residential treatment and are ready for a family home. We firmly believe that family homes are the best places to raise children.

If we looked at the cost comparison between foster homes and group homes, regular foster homes in California receive between $300 and $400 per month per child. Foster homes that care for special needs children such as severely emotionally disturbed received about $800 per month per child. Even with daycare treatment or other community based mental health services, foster home placement is more cost effective. Nationwide, foster home payments average less than 50 cents per hour for children under 13. California has the third highest rate in the nation and we are still unable to recruit enough foster parents to keep up with our needs. Actually, under present circumstances, I personally consider that foster parents are the glue that are keeping our foster care program together and in my estimate, you can equate them with a national treasure at this point because I really do not know what our system would do without them. In the audience today, just to divert for a moment, there are numerous people we can cite but there is a lady in the audience by the name of Beverly Collard and she and her husband have cared for disastrously disabled children throughout the years and what they have been compensated for I do not think would begin to equate what they spent of their own personal finances to care for these children because support services were not available. So, I think the system has to take its hat off to people like Bev Collard who really are in advance of government in facing this issue and dealing with it out of their own personal funds in many cases. So, in addition to foster homes for emotionally disturbed children, there is a critical need for placements for teen mothers and their babies. I certainly applaud your Committee's work in changing Federal law to resolve the problem of inadequate funding for infants placed with their mothers in group homes. However, increases are also needed in foster home rates to attract foster parents to serve this special need population. In summary, I think the Federal government should assume a leadership role in reviewing foster care costs nationwide and in setting realistic standards for reimbursement. We must recognize that foster parenting, at this point, has reached a para-professional level, it is just not strictly a volunteer program. In order to survive now as foster parents, foster parents need an entire network of support services to assist them to keep that child in foster care in the home. We must recognize that foster care parenting is much more difficult than it used to be. Foster parents are a vital part of the professional team and they need training and compensation accordingly. Today's high risk foster children need intensive treatment services, Title IV-E of the Social Security Act must be sufficiently funded to cover the costs of these essential services.

Very briefly, because I know my time is certainly up by now, but I do want to comment on independent living and the importance of that in children's programs. A major goal of child welfare should be to assure that older foster children receive quality of care and services that need to—so they need to become self-sufficient, productive citizens. Now, the great weakness of our system at this time is that it fails to do this. Terminating youth from placement at age 18, unprepared for independent productive adulthood defrauds the youth and adds to the social problems of the community into which he or she is tossed.

Now, independent living initiative is an important first step for several reasons. It helps teens complete education and receive career planning, job training, counseling and instruction in daily living skills. It is highly beneficial but it does not go far enough. Our recommendations would be to extend the independent living services to age 21 and expand the program to include non-federal eligible youth and provide additional services such as pay on-the-job training and money for rent and other living costs. Preparation of foster youth for responsible, productive adulthood has long-range benefits for the youth and society, more likely to avoid homelessness, reliance on welfare, incarceration, chronic dependence on public health and mental health services and repetition of cycle of abuse and neglect of their childhood.

Financing foster care and services that prevent and strengthen families is a responsibility that must be shared by all levels of government. However, fiscal realities nationwide dictate that the Federal government provide leadership to the states to set program guidelines and assure sufficient funding for these programs. Specifically, the Federal government must increase funding for Title IV-E of the Social Security Act beyond the current authorized level to provide a full range of pre-placement prevention and family reunification services create a funding mechanism to authorize use of Title IV-E monies to prevent out-of-home placement by providing home based services for a family whose children are at imminent risk of removal and sufficiently fund Title IV-E of the Social Security Act to provide treatment costs and foster care rates and to adequately reimburse states for foster parent recruitment training and support services and increase funding to prepare older foster children for emancipation and responsible adulthood. I applaud the Committee's concern about foster care issues and appreciate the opportunity to participate in the discussion.

Please be assured of my Department's full support and pursuit of improved programs in this area. Thank you very much.

[Prepared statement of Robert L. Chaffee follows:]

PREPARED STATEMENT OF ROBERT L. CHAFFEE, DIRECTOR, COUNTY OF LOS ANGELES, DEPARTMENT OF CHILDREN'S SERVICES

Good morning Representative Miller and distinguished Committee members.

I am Robert Chaffee, Director of the Los Angeles County Department of Children's Services. My department is responsible for carrying out the Title IV-B Child Welfare Services and Title IV-E Foster Care Maintenance Payments and Adoption Assistance Programs initiated by P.L. 96-272, the Adoptions Assistance and Child Welfare Act of 1980. The department serves 45,000 abused and neglected children at any point in time; 29,000 of these youngsters are dependents of the Juvenile Court, with 23,000 in foster care. According to the 1980 federal census, one out of every 30 children lives in Los Angeles County.

I applaud the Committee's concern about foster care issues and appreciate the opportunity to participate in this discussion.

My statements today will focus on foster care issues in Los Angeles County - with emphasis on the following:

- The need for a broad range of preplacement preventive services to maintain children in their own homes and to facilitate early reunification.

- The increased severity of abused and neglected children coming into the Child Welfare system and their impact on our ability to recruit and retain foster homes.

- The need to better prepare our older foster children for emancipation and productive adulthood through expanding the Independent Living Initiative.

*** BACKGROUND ***

P.L. 96-272

P.L. 96-272 was the most important change in child welfare law in 20 years. Los Angeles County actively supported and worked toward the passage of this landmark legislation. My department fully supports its enlightened philosophy regarding families and children.

P.L. 96-272 reaffirms that, in most cases, the biological and/or extended family is the best place to raise and nurture children. This law requires that services be made available and all reasonable efforts be made to assist families to provide for the health, safety, and well-being of their children. It intended that families with abused, neglected, or at-risk children be provided with necessary support services to enable them to develop and maintain a safe and nurturing home environment. The importance of parent-child relationships and the long-term benefits of maintaining family ties were strongly emphasized.

BEST COPY AVAILABLE

SB 14

In 1982, the California Legislature passed SB 14 to implement P.L. 96-272. While recognizing that there are situations in which the child's safety and development require removal from the home, SB 14 specified that a variety of alternative services be available and utilized to strengthen the family unit before such drastic steps are taken. Many of the recommended services were to be provided in the family's home.

Pilot projects in Shasta and San Mateo Counties in California showed that timely delivery of support services as mandated by SB 14 and P.L. 96-272 were highly effective in preventing out-of-home placement or enabling earlier family reunification. However, nowhere in the country has there ever been adequate funding to fully implement these services. The few programs for preplacement prevention in Los Angeles County are seriously oversubscribed and underfunded. Consequently, law enforcement officers, social workers, and judges have very few options other than removing at-risk children from their homes and placing them in foster care.

*** PREPLACEMENT PREVENTIVE SERVICES/TIMELY REUNIFICATION ***

Last year in Los Angeles County, more than 15,000 children were removed from their homes and placed in out-of-home care. An average of 23,000 children are currently in foster care in any given month. Many of these children could have safely remained in their own homes, and others could have returned home more quickly if adequate family support services had been available.

Although many children must be taken into protective custody because of imminent danger of severe neglect or abuse, many others are removed because there are no other service options. The latter group includes children who are:

- chronically neglected,
- seriously emotionally disturbed,
- substance abusers,
- medically fragile, and
- infants harmed by prenatal exposure to drugs or alcohol.

A variety of in-home and community-based resources would enable parents or extended family to cope with these problems and maintain family unity.

PECOMMENDATIONS

To meet the mandates of P.L. 96-272, it is imperative that programs for the following preplacement preventive services be adequately funded:

- counseling,
- respite care,
- parenting training,
- teaching and demonstrating homemakers,
- temporary in-home caretaker, and
- transportation.

A full range of in-home and community-based programs is essential to develop an effective placement prevention system. Services must be provided for both English and non-English speaking families, and programs must be culturally sensitive to Black, Latino, Asian, and other ethnic communities.

To further respond to families and children with special needs and to prevent out-of-home placement, the following support/ prevention services must also be funded:

- child care,
- treatment for substance abuse, including drug testing for parents,
- day treatment and extended day socialization programs for emotionally disturbed and conduct-disordered children,
- household management,
- intensive in-home support programs such as Family Builders, and
- in-home, health care services for medically fragile children, including AIDS victims.

With adequate in-home health care services, many medically fragile children, including AIDS victims and drug withdrawal infants, could be cared for in their own homes or homes of relatives. The availability of day treatment or extended day socialization programs would enable parents or relatives of emotionally disturbed and behaviorally disordered children to cope with and maintain these hard-to-manage children at home. Teaching and demonstrating homemaker services would prevent the placement of numerous children where the parents' primary need is child care and home management skills. With programs like these, the goals of P.L. 96-272 to keep children at home could finally be realized.

Clearly, the federal government has a responsibility to provide a greater share of these costs by funding Title IV-B of the Social Security Act at the level which will cover the costs of all essential preplacement preventive and reunification services.

Many children receiving child protective services present multiple needs that require intervention from other public agencies, e.g., the Departments of Mental Health and Health Services. The responsibility for serving these children and their families cuts across categorical funding streams. At the federal level, increased recognition of this reality is essential for promoting coordinated action among responsible agencies. Greater interagency coordination is an absolute must if we are to jointly develop needed programs and avoid both duplication and fragmentation of services.

*** FOSTER CARE ISSUES ***

INCREASED NUMBERS AND SEVERITY OF REFERRALS

During the last five years, there has been a dramatic increase in the number of reports of child abuse and neglect in Los Angeles County. Not only are the numbers on the rise, but the severity of the cases has also markedly increased.

Substance Abuse

For example, our 1981-1987 data on petition requests demonstrate the alarming increase in allegations of substance abuse. This includes drug withdrawal or ingestion by young children as well as debilitating drug use by a child's parents.

* Excessive drug use by a parent

1981 - 241 cases
1987 - 1,437 cases (a 500% increase)

* Drug ingestion by minor or infant in drug withdrawal

1981 - 132 cases
1987 - 1,619 cases (an increase of 1100%)

In 1981, substance abuse related referrals represented 4% of the total 9,133 petitions filed.

In 1987, substance abuse related referrals accounted for 18% of the total 16,773 petitions filed.

The above data show that the incidence of substance abuse is increasing not only cumulatively, but geometrically.

Sexual Molestation

Referrals of children who are the victims of sexual molestation have also increased since the enactment of P.L. 96-272. In 1981, there were 1,361 sexual abuse petitions filed in Juvenile Court. In 1987, there were some 2,200 such cases, a 61% increase.

The County's foster care system is straining under the impact of the increased numbers of high-risk children needing out-of-home care. The severe needs these children present require specialized resources and highly sophisticated child care skills on the part of foster care providers.

Increase In Placements

Although we are seeing an overall increase in children entering foster care, the increases are not evenly distributed over age categories. The largest increase is in the infant-to-five age group.

- Overall increase in placements

  1984 - 16,744 children
  1987 - 22,890 children (a 37% increase)

- Infant-to-five age group

  1984 - 5,132 children
  1987 - 7,872 children (a 53% increase)

- Six-to-Twenty age group

  1984 - 11,612 children
  1987 - 15,018 children (a 29% increase)

While the demand for placement has increased during the past seven years, the number of foster home beds in Los Angeles County has not kept pace. This is consistent with the national trend of increased difficulties in recruiting foster families. Los Angeles County has an extreme shortage of family homes for infants and toddlers, for teen mothers and their babies, and for children with special needs, e.g., emotionally disturbed, medically fragile, and drug withdrawal infants.

FOSTER CARE RESOURCE RECOMMENDATIONS

Efforts to increase our foster care resources will need to include greater emphasis on homes of relatives, specialized foster home recruitment, more intensive training, a broader range of support services, and adequate compensation for the greater skills required.

Placement With Relatives

In keeping with the philosophy of P.L. 96-272, we need to increase the number of children who are placed in the homes of relatives instead of foster homes and group homes. However, relatives are faced with the same problems as foster parents as they attempt to care for children who are increasingly impaired and difficult to control. Relatives have the additional burden of resisting the interference and pressures of the children's parents and often of other family members. All too often these placements fail. To be successful, relatives must have more intensive training and support services. Failure in the home of a relative is even more damaging to a child's sense of identity and self-worth than failure in a foster home.

Recruitment

As more and more women work out of the home, our pool of potential foster parents is steadily shrinking. Although many working women might prefer to stay at home, the foster care rates are not sufficiently competitive to enable them to leave higher paying jobs.

Training

More and more frequently, foster parents are confronted with severely emotionally disturbed children, drug withdrawal infants, acting out youngsters, and children with serious medical needs. To meet the challenge, foster parents must have specialized training to develop the necessary child care knowledge and skills. They must also be required to satisfactorily complete appropriate training programs as a condition of licensing or license renewal. Child care must also be provided if foster parents are to participate in such intensive training programs.

Retention

Keeping foster parents has become a losing battle. Foster parents experience failure, become disillusioned, and drop out of the program when they are poorly prepared to deal with troubled children. Adequate training and support services would help them experience success and job satisfaction. Increasing foster care rates would offer additional incentive.

Support Services

All too often, foster parents receive very little support to cope with exceedingly difficult children. The unrelenting demands of the job exhaust the foster parent both physically and emotionally. To enable the foster parent to cope, and to provide needed treatment for the child, the following of support programs are needed:

- respite care to provide relief for foster parents,
- counseling services for the foster family to enable them to cope with family changes caused by caring for problem children in the home,
- day treatment and extended day socialization programs for emotionally disturbed children,
- in-home medical services for medically fragile children, and
- around-the-clock crisis intervention services for foster parents caring for mentally ill or severely emotionally disturbed children.

Foster Home Versus Group Home Care

We recognize that some children need the added structure and supervision that can only be provided in a residential treatment setting. We value these facilities and greatly appreciate the efforts our local group home providers have made in the last few years to develop intensive treatment programs for our most needy children. However, additional foster family homes could in many cases reduce the need for these more costly facilities - both to accept children who do not actually need institutionalization and to receive children who have completed residential treatment programs and are now ready for a family home placement. We strongly believe that family homes are the best places to raise children.

Maintenance payments for children in California placed in regular foster homes range from just under $300 per month to just over $400 per month. Placement in a privately operated group shelter often costs between $2,500 and $3,800 per month.

In situations where foster parents receive higher rates for severely impaired children, the cost of care is still significantly lower than for group home care. For example, maintenance for severely emotionally disturbed children in specially certified foster homes costs about $800 per month. Group home rates for this type child range from $2,500 to $4,000 per month. Even when a day treatment or after-school socialization program supplements the foster home program, the foster home placement is more cost effective.

With foster home payments averaging less than 50¢ an hour for the infant to 12-year-old age groups, no wonder there is nationwide difficulty in recruiting and retaining foster parents. Although foster care payments in California are the third highest in the country, we are still unable to recruit sufficient numbers to keep pace with our placement needs.

Mother-Infant Homes

Within our foster care system, one of the most critical shortages is placement for teen mothers and their babies. There are 170 group home beds for pregnant teens, but only 22 group home beds for the mother and baby. There are only 16 foster family homes serving this population. Fortunately, recent changes in federal law should alleviate the problem of inadequate funding for the infant's board and care in the institutional settings. I applaud the work of this Committee's members toward this effort. However, given the problems of providing care and supervision for a teen mother and her baby, the low foster home rates will not provide sufficient incentive for foster families to open their homes to this special needs population.

To attract foster parents to serve teen mothers and their babies, we must increase the foster care rate for both mother and child and provide training to enable foster parents to handle the special problems the mother-child duo present. The foster parents must be able to nurture, supervise, set limits, and serve as role models for the young mother while at the same time assuring that the infant's needs are met. They must skillfully assist the teenager to prepare for responsible parenthood and emancipation by helping her develop child care and independent living skills. The foster parents cannot handle this task alone. They must have adequate supports such as respite care and child care services. In the community, educational and vocational services must additionally be available for the teen mother.

If a teen mother does not have the opportunity to live with and care for her infant, she may never develop the maternal bonding and attachment necessary for her child's healthy physical and emotional growth. Both mother and child are at risk of perpetuating the all-too-familiar generational cycle of abuse and neglect.

In summary, the federal government must assume a leadership role in conducting a nationwide study of foster care costs and setting realistic standards for reimbursement.

It is an economic reality that more and more families require both parents to work out of the home to maintain a decent standard of living. Foster parenting for altruistic reasons, by necessity, has become a luxury of the past. This is a trend we cannot ignore. It is time we recognized that foster parents are part of the professional team, and that they need training and compensation commensurate with that status.

The need for intensive treatment services for high-risk children must also be recognized, and Title IV-E of the Social Security Act must be funded at a level that will cover the costs of these essential services.

*** INDEPENDENT LIVING ***

A major goal of child welfare should be to assure that older foster children receive the quality of care and services they need to become self-sufficient, productive citizens. Unfortunately, all too frequently this is not the case. One of the greatest weaknesses of the foster care system is the failure to successfully prepare foster children for independent and productive adulthood. The abrupt termination of youth from foster care at age 18, particularly when services to prepare the youth for independent living have not been provided, defrauds the youth and compounds the social problems of the community into which he or she is tossed.

The Federal Independent Living Initiative is a major step toward helping teenagers make the transition from foster care to independent living. This program provides funding for federally eligible foster children to complete their education and receive career planning, job training, individual and group counseling, and instruction in daily living skills. However, as beneficial as these services are they don't go far enough to help foster children achieve true self-sufficiency.

RECOMMENDATIONS

The maximum age for receiving Independent Living services should be extended to 21.

Non-federally eligible children must be equally entitled to these services.

Additional services, such as pay for on-the-job training and money for rent and other living costs must be provided.

The benefits of assisting youth to achieve their full potential cannot be overestimated. Youth who are adequately prepared for responsible and productive adulthood are not likely to join the leagues of the homeless, add to the burgeoning welfare caseloads, increase the ranks of adult felons, create a chronic drain on public mental health resources, nor repeat the cycle of abuse and neglect of their own childhood.

*** SUMMARY ***

I appreciate the opportunity to discuss with you my views on foster care issues in Los Angeles County.

I recognize that funding for foster care and financial support for services that strengthen and preserve families is a responsibility that must be shared by all levels of government. However, fiscal realities nationwide dictate that the federal government: (1) provide leadership to the states in setting program guidelines and (2) assure sufficient funding for these programs.

Specifically, I am referring to the following considerations:

- increase funding for Title IV-B of the Social Security Act, beyond the current authorized level, to provide a full range of preplacement prevention and family reunification services;

- create a funding mechanism to authorize use of Title IV-E monies to prevent out-of-home placement by providing home-based services for families whose children are at imminent risk of removal;

- sufficiently fund Title IV-E of the Social Security Act to provide treatment costs in foster care rates and to adequately reimburse states for foster parent recruitment, training, and support services; and

- increase funding to prepare older foster children for emancipation and responsible adulthood.

Representative Miller, Committee members, please be assured of my department's full support as we pursue the implementation of these recommendations. Thank you.

APPENDIX

INDEX OF GRAPHICS

1. CHILD ABUSE HOT LINE
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2. INCREASE IN PLACEMENTS
   (Comparison of 1984 with 1987)

3. REASONS FOR PLACEMENT
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4. DEPENDENCY PETITION FILING REQUESTS
   (Comparison of 1981 with 1987)

5. SUBSTANCE ABUSE PETITION REQUESTS
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6. SUBSTANCE ABUSE PETITION REQUESTS
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   (Comparison of 1984 with 1987)

8. TOTAL NUMBER OF FOSTER/GROUP HOME BEDS
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9. TOTAL NUMBER OF FOSTER PARENT LICENSES IN FORCE
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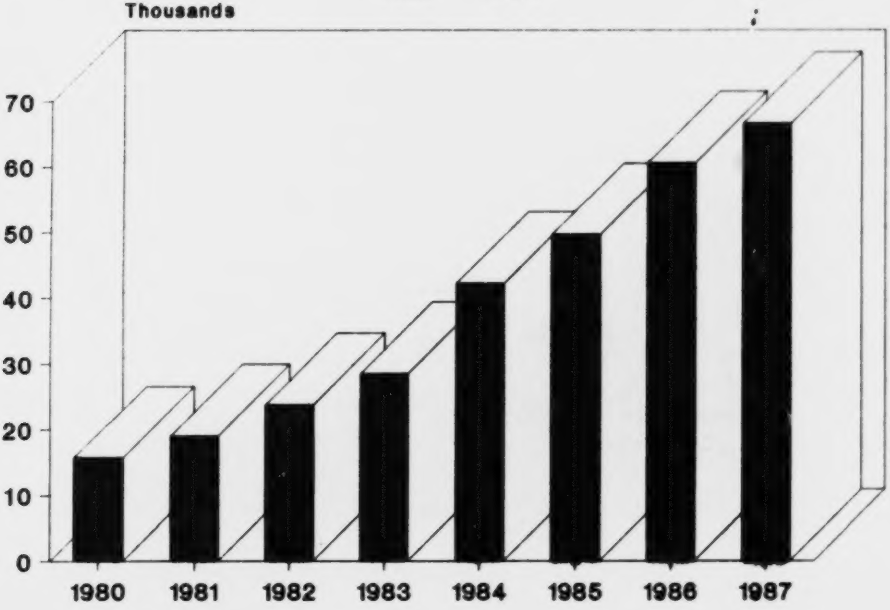
10. REASONS FOR CASE TERMINATIONS FOR PLACED CHILDREN
    (Comparison of 1984 with 1987)

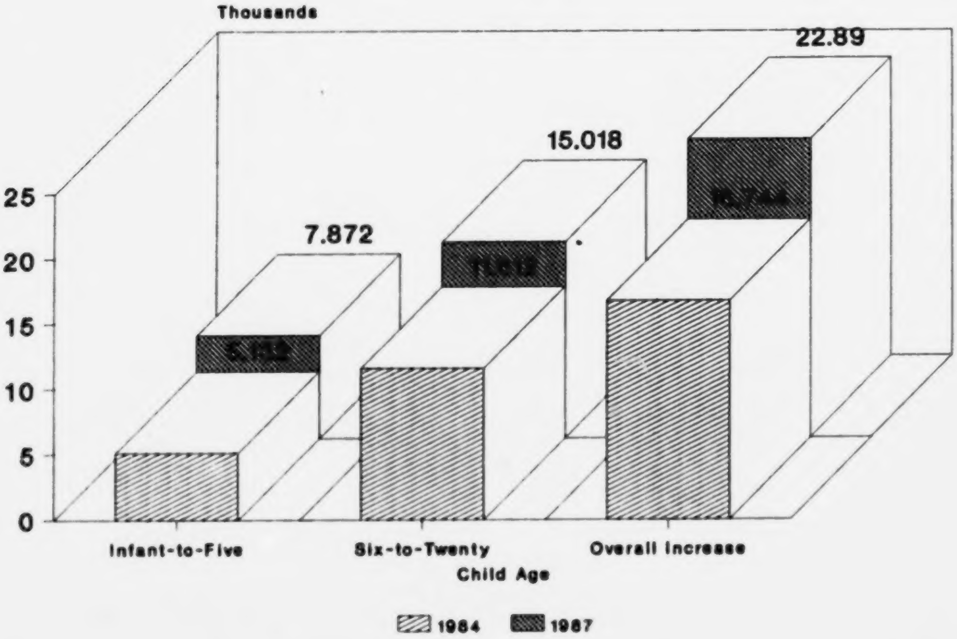
NOTE: Statistics shown on graphs represent a reconciliation of the two major child welfare data systems in Los Angeles County.

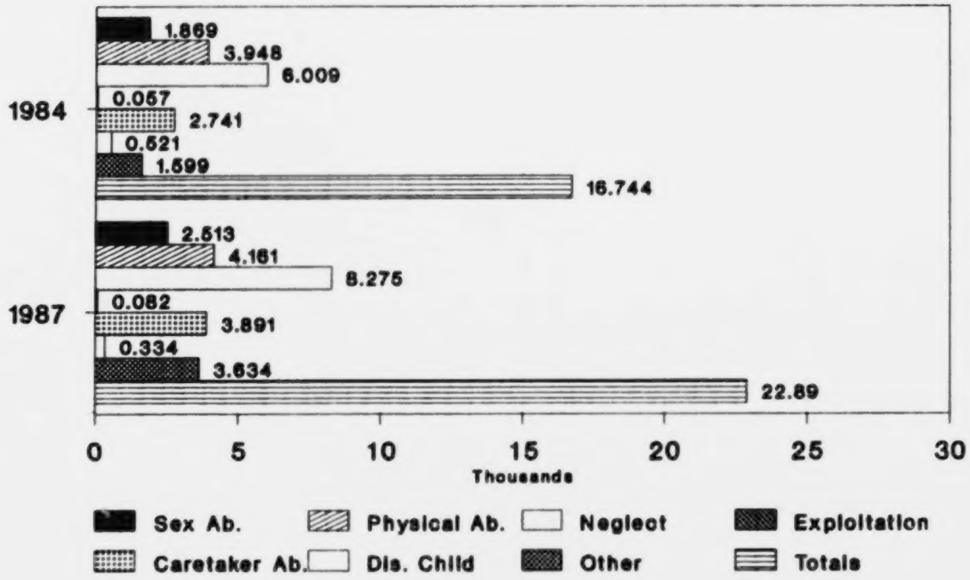
LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES
CHILD ABUSE HOT LINE*
1980 - 1987



* Referrals to the Hot Line represent approximately 60% of all referrals received by the Department of Children's Services.

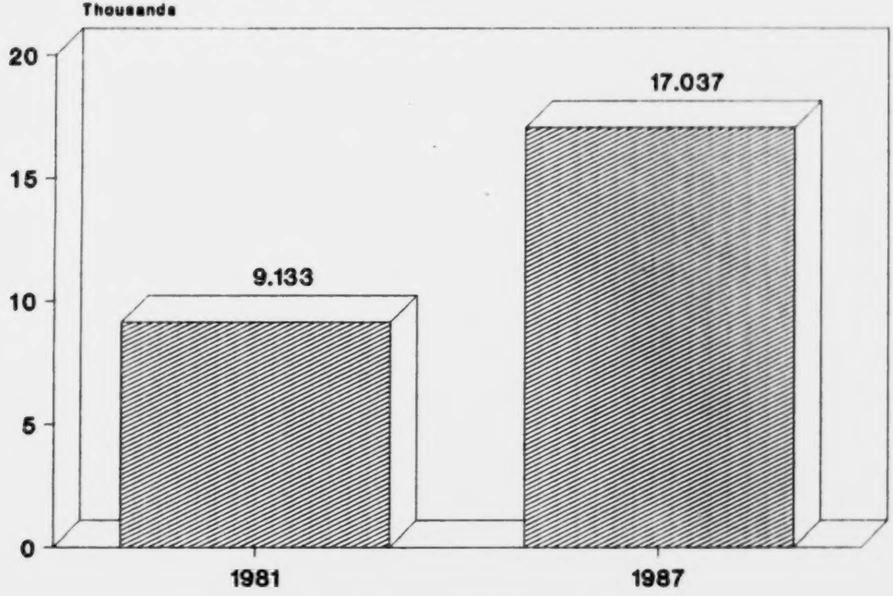
LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES
Increase In Placements
1984 - 1987





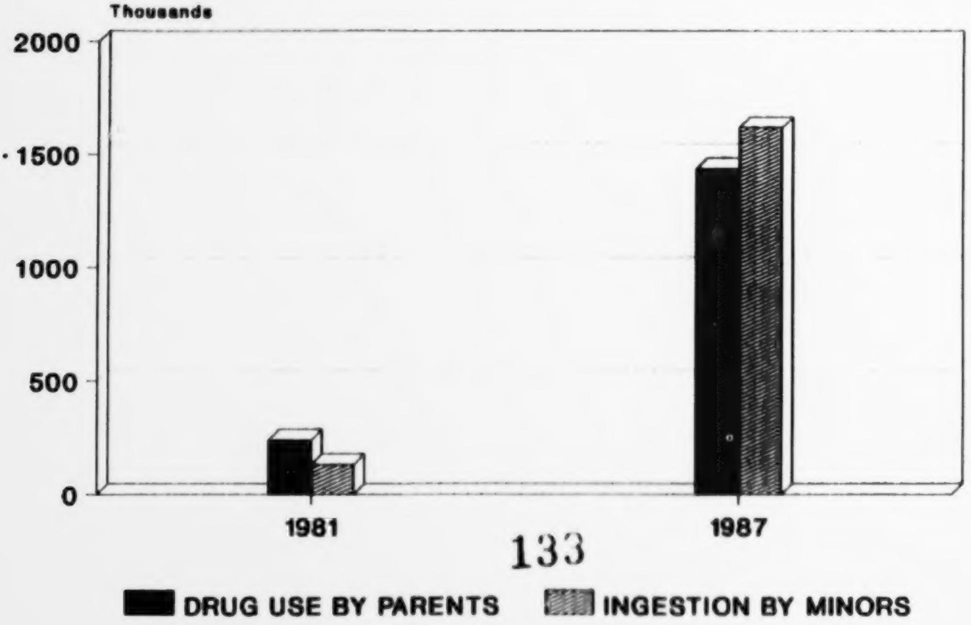
LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES
Reasons For Placement
1984 - 1987

LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES
Juvenile Court Intake
Dependency Petition Filing Requests



87% increase in petition requests between 1981 and 1987

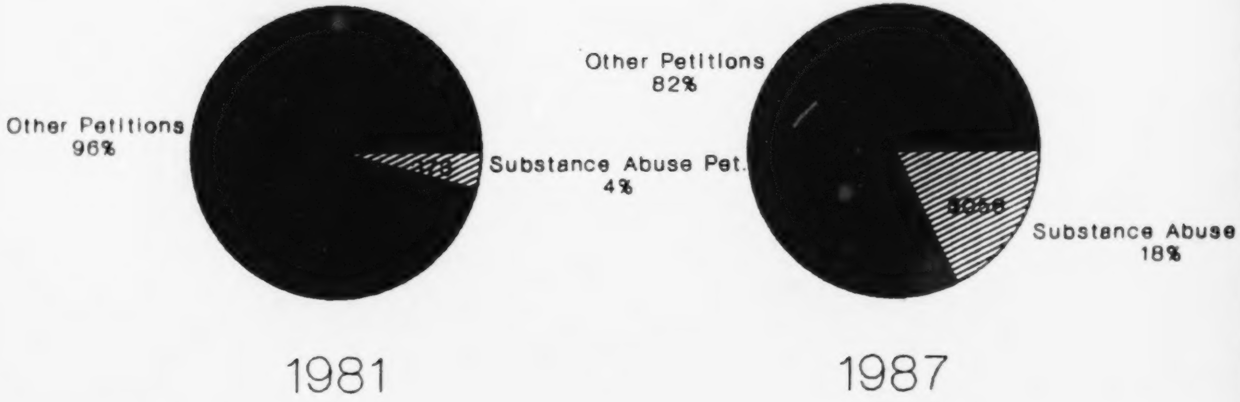
LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES
Substance Abuse Petition Requests
1981 - 1987



LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES

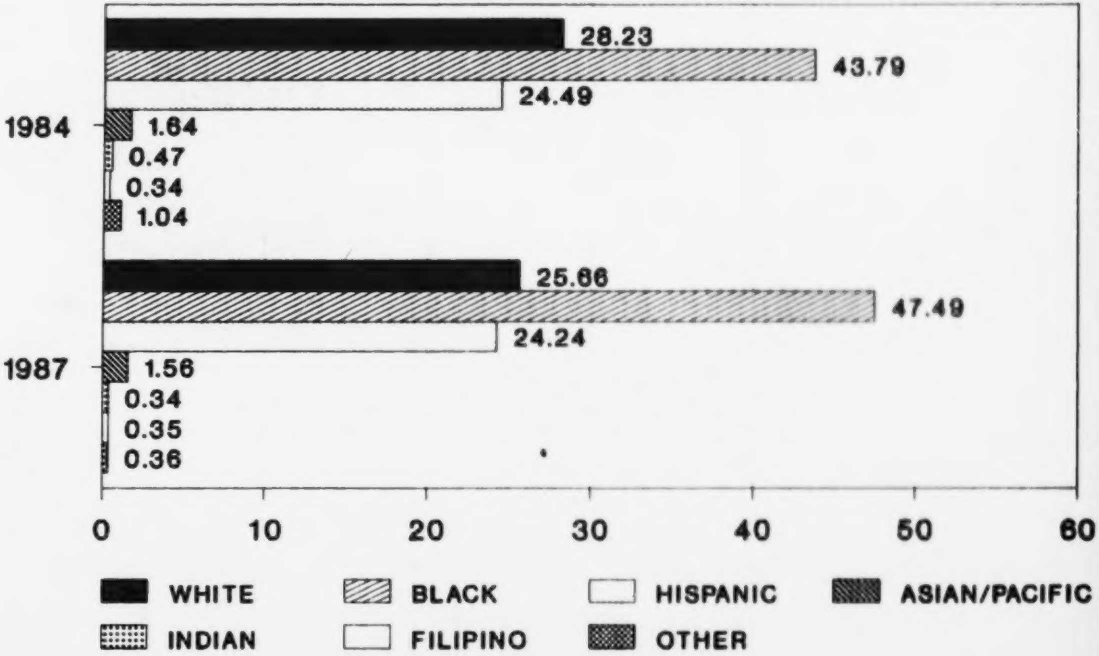
Substance Abuse Petition Requests

1981 - 1987



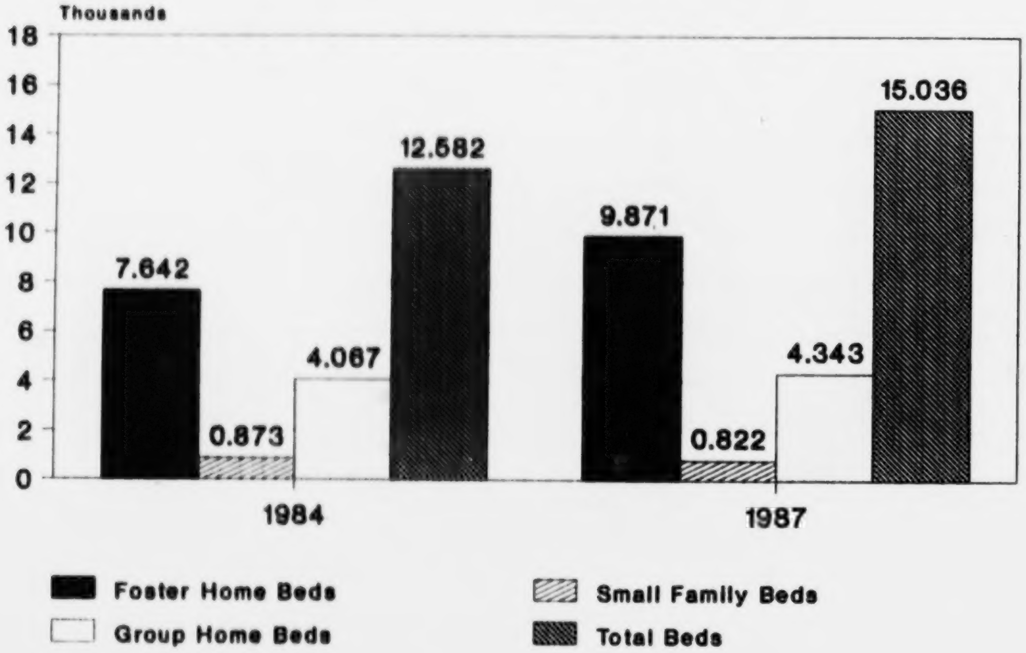
LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES

Ethnic Percentage Of Placed Children

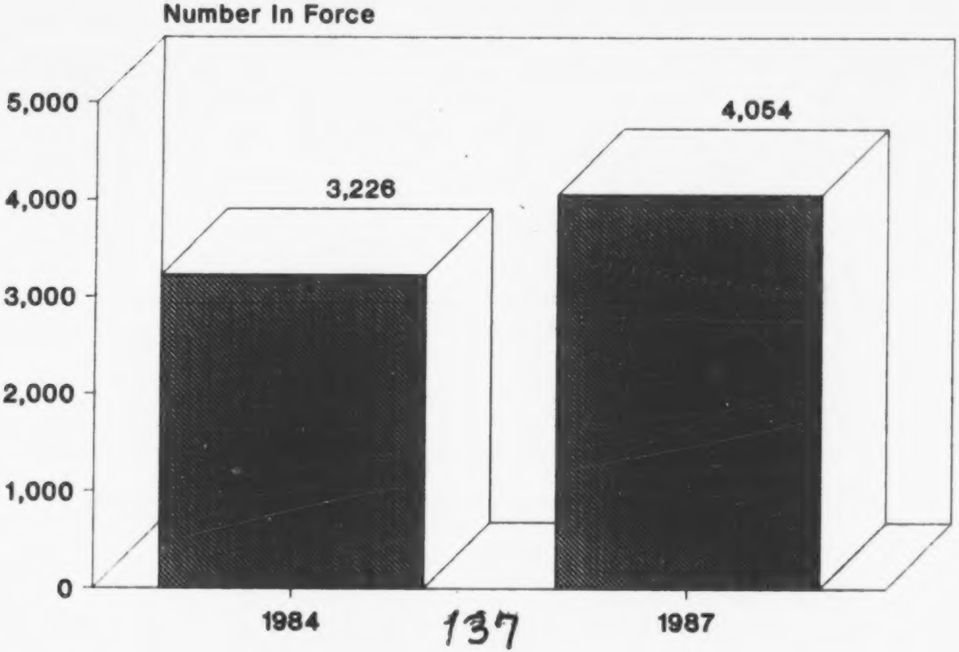


LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES

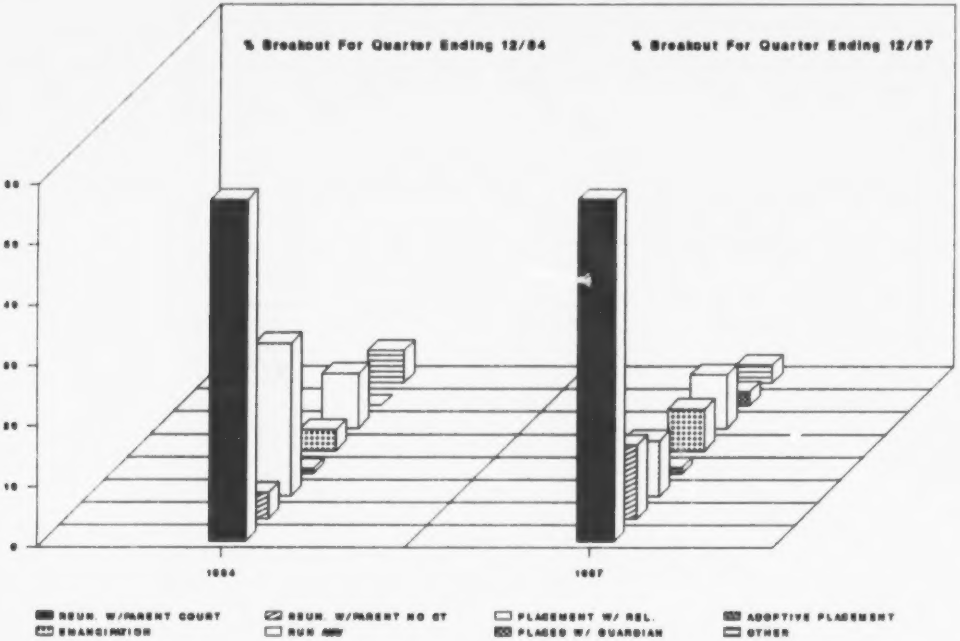
Total Number Of Foster/Group Home Beds



LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES
Total Number Of Foster Parent Licenses In Force



LOS ANGELES COUNTY DEPARTMENT OF CHILDREN'S SERVICES
Reasons For Case Terminations For Placed Children



Chairman MILLER. Thank you. Thank you very much Bob. Nancy.

STATEMENT OF NANCY DALY, CHAIRPERSON, LOS ANGELES COUNTY COMMISSION FOR CHILDREN'S SERVICES, LOS ANGELES, CA

Ms. DALY. Good morning. I, too, am very pleased to be here and I thank you, Congressman Miller and Congressman Dreier and Supervisor Antonovich for—yes, I understand you have to go. But thank you, Supervisor Antonovich for being here. Again, you have demonstrated your support for the needs of children and the recognition that a lot more has to be done in this County.

Chairman MILLER. Let me also thank Supervisor Antonovich for spending some of his time with us this morning. It is rather unusual that we get—we travel to an awful lot of cities and counties around the country, to get local officials to come and spend some time. I think it helps out because sooner or later, most of the testimony gets translated into legislation that you have to live with. We get to design it but you have to live with it. So, I think it is important that we get this kind of relationship established and I appreciate your interest and support in these programs. Thank you.

[Applause.]

Ms. DALY. I feel like I should just say I support everything that has been said and sit down. But I will explain, I am Nancy Daly and I am Chairperson of the Children's Services Commission in Los Angeles County. Our Commission was established about four years ago at the same time as the Children's Services Department because the LA County Board of Supervisors recognized that there was a great deal that needed to be done to coordinate services to children in Los Angeles County. Our commissioners have worked in different capacities in the last four years to bring about improvements in the County but even now, the system has not substantially improved. Again and again, we look to MacLaren Children's Center which is the 24-hour emergency shelter in LA County and it is basically a microcosm of what is occurring in our County and in our State and the problems that we see there we know exist elsewhere except, at least at MacLaren, we can see it. We can see the amounts of—babies that have been there that are drug addicted. We also have become aware that there are institutions being built—to which they are moving these infants, to house these infants because there are no foster parents trained to deal with this population. It seems as if we are going backwards rather than forward in serving these kinds of children. What we realize is that the services that were required by the Federal Adoption Assistance and Child Welfare Services Act of 1980 and State Senate Bill 14 have never gotten off the ground because no funding has been provided. The government has not looked at issues as advocated by these laws. Our Commission, on the day we started became aware of the caseloads that our social workers are burdened with and the fact that there has been no substantial improvement in that area and we could keep hiring social workers forever but until we start to provide the services to families that the workers need to be able to refer and help these families, we are never going to substantially affect how we are keeping families together.

What we recognized in Los Angeles County is that government must provide funding for pre-placement preventative intervention services so that children do not have to be removed from their homes. We must begin at the beginning before the child is born. We must provide adequate prenatal care to insure the babies are born healthy and we must insure that they stay healthy to follow up in-home services to families. We must provide well trained foster parents to care for those children who cannot remain in their homes. As Bob Chaffee has already explained, the cost of institutional care is overwhelming and the cost to keep children in foster homes is inconsequential compared to what it costs to keep them in institutions.

There are often 30 toddlers at MacLaren Children's Center. There is no question that if respite care and child care were available to families and foster families that these children would not be at MacLaren which is the worst possible environment for children of this age. Spending more money for these children at this point in their lives will certainly save us all money in the future.

Recently, a foster mother who was subsidized by United Friends of the Children which is a volunteer group that also supports MacLaren Children's Center, told me that her goal is to keep the 6 adolescents in her care off of welfare and out of jail. She has been a foster mother for 12 years and it ends up costing her money to be a foster mother. Two of the girls in her care will go to college next year and one to a trade school. The other three will finish high school and all of these girls have jobs. We need thousands more like this devoted foster mother, but we must first begin to recognize their professionalism and pay them for their expertise.

It is our belief that every child who enters MacLaren Children's Center is in need of mental health services. They require proper assessments and referrals for services and the services have to be developed. Again, if we spend the money early on, we avoid the cost of supporting these very same human beings on welfare and we avoid the obvious expansion of our homeless population.

At MacLaren Children's Center, many of the mental health children are requiring one on one attention from the staff in order to protect them from themselves and to protect the other children. These are children who belong in mental health facilities but these places are not being provided by mental health. The children do not belong at MacLaren Children's Center but until Mental Health is willing to make children a priority, these troubled youngsters will continue to be placed in the Center, draining the staff and prohibiting them from doing anything productive in helping the abused and neglected children in their care.

Judges must become more knowledgeable about the services and the lack thereof that exist in our County. They must insure that children and families are receiving the services that they order and they must hold the system accountable when it fails. Again, at MacLaren Children's Center, recently we have seen, again, the problems that exist in our County, because—we have a gang sweep going on. Due to the terrible conditions we have with gangs in this County, there are children who come into MacLaren Children's

Center exhibiting gang type behavior. They may not necessarily be members of gangs but they have copied the behavior of family members and people in their community. Again, we need to provide services to this population. We must find ways to reach these children before they look to gangs for the kind of support that they are not getting from their families or from their community.

For children with needs that require services from both Mental Health and Children's Services, neither department wants to acknowledge responsibility because responsibility costs money and there are just no funds available for children. Our government must make children a priority and fund the services required in the legislation of 1980. If we do not build a strong foundation for our youth, we will have to build bigger and stronger institutions in which to have them. We need to invest in our children now before we destroy them.

[Prepared statement of Nancy Daly follows:]

PREPARED STATEMENT OF NANCY DALY, CHAIRPERSON, LOS ANGELES COUNTY COMMISSION FOR CHILDREN'S SERVICES, LOS ANGELES, CA

My name is Nancy Daly and I am Chairperson of the Los Angeles County Children's Services Commission.

I originally became involved in children's issues as a volunteer with the United Friends of the Children, a group which I founded eight years ago to bring some comfort and support to the abused and neglected children at MacLaren Children's Center, Los Angeles County's 24-hour emergency shelter.

When I began at MacLaren, the population seldom reached the maximum capacity of 140. Currently the capacity is 300, and very often the population reaches that number. The interesting phenomenon is that there has been no increase in space -- no expansion of the buildings, but somehow, miraculously, the capacity has grown from 140 to 300.

Eight years ago MacLaren was run like a probation facility, even though it had changed from a probation to a protection facility several years earlier. The problem was that nothing else changed -- the staff and environment were still the same. So, the abused and neglected children placed there for protection were treated as if they were juvenile delinquents -- the staff had not been trained to deal with this new population.

I became aware of the gross neglect that was occurring in this County with regard to serving the needs of this population, and I worked very hard with my friend and fellow Commissioner Stacey Winkler to bring about improvements at the Center and the creation of the Children's Services Department.

Through the creation of the Children's Services Department and the Commission for Children's Services, the County has come a long way in improving the conditions at MacLaren Children's Center.

The Commission was established four years ago by the Los Angeles Board of Supervisors. There are fifteen private-sector members who receive no funding from the County. Our mandate is to oversee the activities of all departments in the County as they relate to serving children. Our role is to work with the individual departments that provide services to children, advise them in areas where there may be a need for improvements, and report to the Board of Supervisors on a regular basis. During the past several years we have worked very closely with the Children's Services Department to help them in their endeavor to improve services to children. I have attached a list of some of our activities.

All of our Commissioners have worked in different capacities to bring about improvements in the County. Even now, however, the system has not substantially improved. There is a greater awareness of the problems, and our Board of Supervisors has demonstrated its support for children by supporting the Department and the Commission. However, the services that were required by the Federal Adoptions Assistance and Child Welfare Services Act of 1980, and the State Senate Bill 14, have never gotten off the ground because no funding has been provided. The Government has not looked at issues as advocated by these laws.

What we have recognized in Los Angeles County is that Government must provide funding for preplacement preventative intervention services so that children do not have to be removed from their homes. We must begin at the beginning -- before the children are born. We must provide adequate prenatal care to ensure that babies are born healthy, and we must ensure that they stay healthy through follow-up in-home services to families.

We must provide well-trained foster parents to care for those children who cannot remain in their homes. The cost of keeping babies in hospitals and other institutions is prohibitive -- over $3,000 per month at MacLaren Children's Center, while it costs between $200 and $800 for children in foster homes.

There are often 30 toddlers at MacLaren Children's Center. There is no question that if respite care and child care were available to families and foster families, these children would not have to be placed in institutions -- the worst possible place for children of this age. Spending more money for children at this point in their lives will save money in the future.

Recently a foster mother who is subsidized by United Friends of the Children told me that her goal is to keep the six adolescents in her care "off of welfare and out of jail". She has been a foster mother for 12 years, and it costs her money to be a foster mother. Two of ther girls will go to college next year and one to a trade school. The other three will finish high school, and all of them have jobs. We need thousands more like this foster mother, but we must begin to recognize their professionalism and pay them for their expertise.

It is our belief that every child who enters MacLaren Children's Center requires Mental Health services. They need proper assessments and referrals for services; and the services have to be developed. Again, if we spend the money early on, we avoid the cost of supporting these same human beings on welfare, and we avoid the expansion of our homeless population.

At MacLaren Children's Center, many of the Mental Health children are requiring one-on-one attention from the staff in order to protect them from themselves and to protect the other children. These are children who belong in Mental Health placements which are not being provided by Mental Health. Until Mental Health is willing to make children a priority, these troubled youngsters will continue to be placed at the Center, draining the staff and prohibiting them from doing anything productive in helping the abused and neglected children in their care.

For children with needs that require services from both Mental Health and Children's Services, neither department wants to acknowledge responsibility, because responsibility costs money and very little funds are available for children.

Our government must make children a priority and fund the services required in the legislation of 1980. If we do not build a strong foundation for our youth, we will have to build more and bigger and stronger institutions in which to house them. We need to invest in our children before we destroy them.

Below are some of the activities of the Los Angeles County Children's Services Commission:

1. Recommended the hiring of a management consultant who has brought together labor, management and the private sector to totally reorganize the Children's Services Department so that it can more successfully address the needs of children.

2. Co-ordinated the establishment of the Children's Planning Council which is co-chaired by Mr. Robert Chaffee, Director of Children's Services, and Dr. Sharon Watson, the Director of Crittenden Center, a home for young women. This Council brings together the private sector and the Department so that they can do long-term planning for the needs of children as well as address the more pressing needs that currently exist.

3. Worked with the Chief Administrative Officer, Department Directors and members of the private sector to begin to plan for program budgeting for children.

4. Worked extensively with the Department to find the current Director of MacLaren Children's Center, L.A. County's 24-hour emergency shelter for abused and neglected children. During the past four years, the Center has been transformed from a probation-type facility into a warm and attractive environment for children. We continue to concentrate our energies on the overcrowding of the Center, the problem of Mental Health clients at the Center because there are not enough Mental Health beds for troubled youth, and the presence of a disturbing number of children who demonstrate gang related behavior. Since raising

4. continued:
these concerns regarding gang activity, Mr. Chaffee has contacted the Probation Department and Sheriff's Office to co-ordinate some actions to address this critical problem and to create programs that will reach these young people before it is too late. The Court is also involved in this effort.

5. Co-ordinating the County's effort to create child-care programs in the County. The Commission is responsible for bringing together the different agencies working on child care, City and County representatives, and representatives from major corporations that have created child-care programs such as Disney, as well as business representatives who are interested in learning about the over-all need.

6. Discovered that the Department of Mental Health had not complied with the Egland requirement that 30% of all new dollars must be applied to programs for children for fiscal year 86-87. Because of this discovery, $1.8 million was put into children's services for fiscal year 87-88.

7. Worked with the Department of Health Services and the Child Health Network to improve the Department's pre-natal care. Encouraged contracting with clinics to cut down the amount of time women must wait before being seen by a doctor. We continue to monitor this program.

8. Worked with the Chief Administrative Office and the private sector to form a permanent Council that will address the problem of adolescent pregnancy.

9. Our Legislative Committee coordinated the Sheriff's Office, City Attorney's Office and LAPD's effort to get clarification regarding the restrictions placed on their ability to protect children under SB243. Through this coordination effort, clean-up legislation has been proposed by Senator Presley to address these concerns.

10. Worked with the Dependency Court, private sector representatives and County representatives to develop an assessment document to be used by social workers in evaluating whether or not it is necessary to remove children from their homes.

In our Committees, we continue to address problems related to Foster Care, Data Processing, Mental Health Services, issues relating to social workers, and areas that relate to public/private co-ordination.

We intend to concentrate more time on the needs in the Probation Department in the coming year.

Chairman **Miller**. Thank you. Thank you very much.

I would like to, at this point, before I start questioning, recognize Congressman Dreier who has joined us this morning for an opportunity to make a statement or to ask questions. Whatever you would like to do, David. Thank you very much for joining the Select Committee.

STATEMENT OF HON. DAVID DREIER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. **Dreier**. Thank you very much, Mr. Chairman. I greatly appreciate the opportunity to be included here today and I want to say at the outset that I have appreciated the three witnesses from whom I have heard and apologize that I was not able to be here earlier. But I will say that I look forward to listening to all the testimony. And I want to say, Mr. Chairman, that I appreciate not only the sacrifice that is made on behalf of all of the witnesses who are here who have a critical interest in this issue but also everyone who has played a role in participating and being a part of this very, very important issue.

I am very encouraged by the growing attention which has been focused on the whole issue of children in crisis. There is no question, in my mind, that America's children are at risk and it is imperative that we not only recognize the problems but that we find workable solutions to reversing the alarming facts and trends which have taken place and I know this Committee is doing that.

Thirty years ago, less than one baby in twenty was illegitimate and now one in five is illegitimate and although the stigma of illegitimacy is no longer as strong, these children are clearly at a disadvantage. Some of these children never get a chance as unwed women have a much higher rate of abortion than married women. If these victims are fortunate enough to be brought to term, there is a good chance they will be born with a low birth weight because of the lack of prenatal care and they will most likely be one of the millions of children growing up in a female headed home of which more than one-third of such families are living below the government's official poverty line.

Not only will they be poor but they are more susceptible to a host of other problems including crime, drugs, school dropout and teen pregnancy as has been pointed out. Illegitimacy though is only one of many problems as has been pointed out. Perhaps we should take a look at some of our other Federal policies. Aid to Families to Dependent Children is not available to intact families. Most women and children are better off on welfare than struggling to make ends meet with a husband's low paying job. This only legitimizes irresponsible fatherhood and out-of-wedlock births. Family breakdown almost insures crisis for children and yet our largest policy insists on a broken family.

Take our Child Care policy. We encourage mothers to put their children in subsidized child care while they go out and work yet we do not offer any assistance to those poor working families who have made a sacrifice to keep one parent at home with the children. I co-sponsor legislation to offer a tax credit to families with pre-school children regardless of whether or not they participate in the commercial child care market. The bill targets maximum benefits to those families with the greatest financial need. This will allow mothers who sacrifice their own careers to care for their children to be treated similar to women who want or need to work.

And take our response to unwed pregnant teens. California is the only state with a maternity home care program. Maternity homes, problem pregnancy counseling and adoption services are critical in order to protect the lives of these children before they are born. I am studying the issue of maternity homes with hope of introducing legislation to target funds in the Social Services Block Grant for maternity home services. Maternity home services have a direct impact on the numbers of young women who carry their children to term, on the numbers of babies born in better health and on the number of couples who would have an opportunity to adopt.

In California, it has been estimated that the adoption rate is five times higher when women are at a maternity residence and I do not think I need to remind you of the thousands of couples who are waiting to adopt. Maternity homes can provide young women with counseling, mothering skills, vocational, education classes and post-natal care skills. Not only would incalculable human costs be saved but government welfare costs would be substantially reduced. I figure the cost benefit ratio could be at least two to one.

PREPARED STATEMENT OF HON. DAVID DREIER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I appreciate the opportunity to be here today. I regret that I could not be here earlier as I know there have been a number of very good witnesses and I wish I had had the opportunity to have heard them. I look forward to reading their testimony which was submitted for the official record.

I am encouraged by the growing attention focused on "children in crisis." There is no question that America's children are at risk and it is imperative that we not only **recognize** the problems but that we find workable solutions to reversing the alarming facts and trends.

Thirty years ago, less than one baby in 20 was illegitimate; now, one in five is illegitimate. Although the stigma of illegitimacy is no longer as strong, these children are clearly at a disadvantage. Some of these children never get a chance, as unwed women have a much higher rate of abortion than married women. If these victims are fortunate enough to be brought to term, there is a good chance they will be born with a low birth weight because of a lack of pre-natal care, and they will most likely be one of the millions of children growing up in a female-headed home, of which more than one-third of such families are living below the government's official poverty line. Not only will they be poor, but they are more susceptible to a host of other problems including crime drugs, school drop out, and teen pregnancy.

Illegitimacy is only one of many problems. Perhaps we should take a took at some of our federal policies. Aid to Families With Dependent Children is not available to intact families. Most women and children are better off on welfare than struggling to make ends meet with a husband's low-paying job. This only legitimizes irresponsible fatherhood and out-of-wedlock births. Family breakdown almost ensures crisis for children and yet our largest welfare policy insists on a broken family.

Take our child care policy. We encourage mothers to put their children in subsidized child care while they go out and work. Yet we do not offer any assistance to those poor working families who have made a sacrifice to keep one parent at home with the children. I have cosponsored legislation to offer a tax credit to families with preschool children regardless of whether or not they participate in the commercial child care market. The bill targets maximum benefits to those families with the greatest financial need. This will allow mothers, who sacrifice their own careers to care for their children, to be treated similar to women who want, or need, to work.

And take our response to unwed pregnant teens. California is the **only** state with a maternity home care program. Maternity homes, problem pregnancy counseling, and adoption services are critical in order to protect the lives of these children before they are born. I am studying the issue of maternity homes with the hope of introducing legislation to target funds in the Social Services Block Grant for maternity home services.

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Again, thank you Mr. Chairman for the opportunity to be here and for all of your hard work on behalf of "young children in crisis" both in Los Angeles and throughout the country.

Mr. **Dreier**. Once again, Mr. Chairman, let me say that I greatly appreciate being included here today and I am not a member of your Committee. But I would, if I might, just like to ask a couple of questions.

Chairman **Miller**. Sure.

Mr. **Dreier**. First of Mr. Chaffee. I would like to pursue the who issue of foster parenting and I wonder first, if there is any major recommendations as to how we might be able to proceed at expanding opportunities because it has been demonstrated through almost all of the witnesses whom I have heard from today that this is a program which needs to be expanded and are there specific legislative recommendations which you might have for us as we hope to expand what certainly is a very important program.

Mr. **Chaffee**. Well, Congressman, two or three things. There are several things that could be discussed but I think first and foremost, a strong national recognition of the job that foster parents are doing. They may sound simple but one thing I have run across is the problem of taking foster parents and their role for granted without enough national or even state recognition of the role is——

Mr. **Dreier**. Well, you made that clear by just pointing out foster parents who are here today. And I think I, from your message, will assure you that in my communications with the constituents I have that I will try to put this on the front burner and let people become more aware of it just as far as that.

Mr. **Chaffee**. Well, I thank you for that. Then two other things quickly, and there could be a longer list, but certainly recognizing it is a paraprofessional program and realizing that the foster parent, oftentimes, may need the same services as a parent with a child in the home. Meaning, recourse to respite care. These children are cared for around the clock. There should be some review of the kind of training that foster parents need, their need for respite care and to let that child go into perhaps a daycare setting for half a day to give the foster parents some rest. So, there is a whole network of what I would call support services that should be carefully examined for foster parents.

And also, quite frankly, since—and I emphasize it is my belief, that the vast majority of foster parents are spending money in order to have foster children. They are not, of course, making any money from this program. The needs of foster children today are such that the reimbursement rate we have is woefully inadequate to cover their needs and my point, of course, even if you did not look at it on a philosophical basis of where the best place for the child would be, just from a sheer economic basis, the fact is that you can care adequately for a child in a foster home in a family setting at a terrifically reduced cost from what it costs to institutionalize that child. And I believe that many fragile children—we have done it in Los Angeles and other communities have too, the fragile, medically abused children can be successfully cared for in foster parent homes if they have the proper support service to maintain them there.

Mr. **Dreier**. Let me pursue that last line if I possibly can. That is, is there adequate disclosure concerning children as far as emotional or behavioral problems which parents have found really after the fact rather than before. I mean, is there anything that we can do to improve disclosure of any problems that do exist?

Mr. CHAFFEE. Well, if I fully understand your question, Congressman, I think it is on several levels. First of all, we have to have adequate services available to children to make sure we are getting adequate assessment of their medical and psychological and psychiatric problems, adequate evaluations to insure we know the type of child we are treating. That is for openers. Then——

Mr. DREIER. Then is it disclosed to the potential parent? Is all of that information made available?

Mr. CHAFFEE. Well, it may—yes. But it works two ways. In other words, the parent needs that information if we are going to maintain the child in the home but also it helps us validate the kind of child we are dealing with which the parent, either in ignorance or perhaps hiding it from the agency, does not share the true problems or background of the child.

But the second level is, quite frankly, also within the agency, if you have a highly overworked staff, working with multiple parents, you have got to make sure that that staff has the time and resources to get adequate information on the child to share with the foster parent. Because one issue that can arise that does not bond the foster parent with the agency or causes friction is leaving children with foster parents without leaving the foster parent with adequate information as to the total, you know, emotional and mental health care needs of that child.

Mr. DREIER. Ms. Daly seemed to want to respond.

Ms. DALY. Well, all I have to do is turn around and look at some of our workers, social workers, who are sitting here and who have these enormous caseloads and very often I have to say that there are no records that are available. I use MacLaren Children's Center again and again because there we have the children in front of us, you have the school there, Mental Health is there, Health Services, and the Department of Children's Services and even there, the records do not get from one building to the next; even from one caring person to another. The organization of this information and sharing the information just seems to be impossible. And I do not know what the solution is but we sure have not found it yet.

But I will tell you that the foster parents get children they know nothing about, what their problems are, and they find them out on the job. And very often, that is how a child ends up—what is described as failing in placement. And every time a child comes back to MacLaren Children's Center, that is how they are diagnosed—I failed again. And it is not that they have failed; we have failed them because these foster parents do not have a clue on how to deal with the problems of the children they get.

Mr. DREIER. So, that is why we should try and prove that whole disclosure—but let me just say, Mr. Chairman, thank you very much and again, I very much appreciate the sacrifices which all of you have made and especially those who are involved in this program. Thank you very much.

Chairman MILLER. Thank you.

Let me start with you. You are telling us—I assume you are telling this to the State legislature too, that in no uncertain terms, they are blowing $30 million a year by not providing prenatal care.

Ms. **Lazarus**. In California, we have seen an 80 percent increase in the funds spent on sick newborns through our State's Medi-Cal program. That is just in the last three years. During that same period, the number of babies born increased only 11 percent. So, the numbers speak for themselves, that we could invest our dollars more effectively.

Chairman **Miller**. Well, I am trying to get the three of you tied together here. Doctor Bean is telling me that we are seeing more mothers at potentially higher risks than we might have seen before either because of drug use or other environmental factors who are likely to deliver child with some problems. You are telling us that even once we have counseled her to get prenatal care, that certainly in LA and Orange County and San Diego, we are turning that mother away once she has made the decision. So, we have taken a high risk individual, told her to get enrolled in the program, the programs that she is eligible for now turn her away, and in one of your testimony, I think maybe it is yours, Doctor Bean, suggesting that she cannot get an appointment until after delivery date. I do not want to pretend that that is the norm, but can this really be the case?

Ms. **Lazarus**. Yes, that can be the case. We are talking about two challenges. The first is to reach that group of women who are already knocking at the door. They know they need care, but because we have too few services, they are either being turned away—as in San Diego County where 5,000 women were turned away last year—or put on dangerously long waiting lists.

Chairman **Miller**. What happened to them when they were turned away?

Ms. **Lazarus**. Many of these women are getting no care at all. The UC-San Diego Hospital has seen a 31-percent increase in the number of women delivering their babies there who have had no prenatal care at all. Some of them are able to find a generous physician who will see them, but many of them get nothing. So, the first order of business is to take care of the women knocking at the door.

The second order of business, once we have some services in place, is to do better outreach to some of the higher risk women who are not now coming in.

Dr. **Bean**. I think that one of the things you have to remember is that, as a medical professional, we equate prenatal care with good care and also with how well we are doing in this Country in terms of providing overall medical care. The message, however, that we give out to the community by limiting access to medical care, to prenatal care, and making it so difficulty to acquire prenatal care, is that society has decided that prenatal care is not essential anymore. In Los Angeles County, it used to be free to get prenatal care. I rarely, if ever, saw anybody with no prenatal care up until the last few years. Even in my substance abusing population, in 1981, only 28 percent of them had no prenatal care. They were all able to acquire prenatal care. But, by putting obstacles in the way of people acquiring prenatal care, the message is very clear in the community that society, and in this case, the public sector, or the people who run our Country, have decided that prenatal care is no longer considered essential, it is no longer considered a right for people to have.

And then, if you take a population such as mine in which—a very high risk population with many problems, any obstacle to prenatal care is especially important for them.

Chairman MILLER. But the end of that story is that we are spending this $30 million unnecessarily. Just separate out the tragedy of what happens to many of these newborns and their families, on whom we are now spending this $30 million that we need not spend had we provided first class prenatal care which I think the Academy of Pediatrics and others have suggested. This prenatal care is about $600 or $700 a pregnancy on the average because a lot of it is counseling, taking care of yourself, stopping alcohol consumption and smoking and so forth. Which then gets us to Doctor Lesh because what you are saying is then, after we screwed up once and we have now invested $40,000 on the average in getting this kid into a condition where he can thrive, we walk away from him. We send him back into an environment where there is little or no understanding of how to take care of this child, the child does not do well, the mother gets depressed, the child does worse and now we have got a full-blown crisis on our hand all over again. I mean, if I had to chart this in the corporate board room, nobody would invest in this system.

Ms. LESH. Well, I think you have said it very well and I think we do literally abandon them after hospital discharge. What has happened with Wendy's statistics is that they are being translated into actual real live babies for us. We are dealing with in the home situation and prematurity that have resulted in multiple problems that are not being seen by others. It is extremely difficult to turn away families that have the kind of severity of involvement of their infants simply because we have no funds to provide services. I think, we have known all of this (importance of prenatal care and follow-up) for a long time. This is not news to any of us. Our program was established as a model in 1979 and, when we talk about what has changed, what has changed is the numbers. (The situation) has become more severe. It has become more intense. But all the issues were present in 1979. Legislators were attempting to deal with it at that point in time but things have not progressed. There has been, for example, no cost of living increase in our particular program, since we started. There has been no attempt to provide additional or increased funding for these 75 percent babies that we are now turning away when we have clearly documented, that they are every bit as high risk as the ones we serve. Every bit as needy! They are not only at risk for failure to thrive but are really at risk for death.

Chairman MILLER. When we talk about the return on our investment in terms of prenatal care and nutrition like the Women, Infants and Children's Program in a discussion in the Congress, we cite that we get back three dollars for every dollar we spend, but we stop measuring that return at the intensive care unit. There is no discussion about the on-going costs after that child leaves the intensive care unit and I think we would get great support for the

WIC program on a bipartisan basis in the Congress because enough members of Congress have visited an intensive care unit and have said you mean I can stop that. And you say, yes you can stop that. And they will buy into that. But what your program is suggesting to us is that we now start to have a whole new series of costs because the miracle that was performed in the intensive care unit in taking that tiny child and turning him into some kind of bouncy little fat kid is now being lost once again because we are sending him back into an environment where the failure to thrive and all the attendant problems are going to reoccur.

Ms. LESH. Well, the environment in which that baby was initially conceived and cared for prenatally also continues to exist afterwards. So, the very environment that Wendy is talking about and that Doctor Bean are talking about in terms of—that creates these high risk premature babies continues to exist. What we are saying is that we can take care of them in the hospital, we can get them to the states where they can go home but you are then discharging them into the very same environment that created the initial premature birth weight——

Chairman MILLER. And your—if I read your——

Ms. LESH. Without any additional resources for these families.

Chairman MILLER. If read your—somewhere in your testimony, you are indicating to me that I can protect my $40,000 investment in that intensive care unit for about $1,000 a year per family?

Ms. LESH. That is right. It costs us about $1,000 to follow in home. And you know, when you think about it too, even in the figures that were cited for foster care, that is about the equivalent of one and a half months worth of foster care. So, in other words, I think maybe we need to look at providing the kind of environment for the families and the mothers that will allow them to take care of their own babies first of all and only use the foster care and the other systems as a backup when there is clear failure and inability to do so. But, I do not think we are providing the kind of environment—that allows a mother to take care of her infant. This deals with the issue of childcare too, because if you have a sick baby, even if you can afford it, childcare is not available to you. I mean, babies on apnea monitors, babies with tracheostomies, babies with gastrostomy tubes are not being able to—you cannot find a babysitter that is willing to take that baby.

Chairman MILLER. Which gets us to foster care. First of all, Mr. Chaffee, let me thank you and thank LA County because when we did re-write the law 96–272, the County was very, very important and also very helpful in that effort. I would have to say, I will tell you right up front, that you are correct. We failed in our part of the bargain. We told you if you would change your laws and start to make an investment in pre-placement and reunification services and set up a system to develop that program, that we would help pay for those services and we have essentially stood still since the passage of that law in terms of the resources available to counties and what we are seeing reoccurring around the Country now, while we had an initial success and we were starting to reduce the number of children entering, certainly young children entering foster care in almost every region of the Country, we have now seen all of those caseloads start to creep back up. We are kind of back where we were in 1980. I think that is why the Ways and Means Committee, along with this Committee is engaging in that oversight with the expectation that we will report out legislation the beginning of—probably next year. Because we cannot afford it.

Once again, it seems that every time we dip our hands into the till as policymakers, we reach for the most expensive solution when the least expensive and the most effective solution is right in front of us. In foster care, we now find that we are increasingly reaching, once again, for group homes, for institutionalization, when foster parents are in front of us, or relatives are in front of us but we will not treat them the same as we would treat a group home or an institution. One of the things that struck us in 1980 was this phenomenal expenditure we would make on the institutionalization of children, in many instances, with no services—just sort of warehousing of these children, we spent thousands of dollars a month but we would not give a foster parent an additional $50. I think what we heard yesterday in Ways and Means was that we have now not only victimized the children, we are starting again to victimize the foster parents because they are reaching into their pockets.

If you listen to the parents, the foster parents of adolescent children describe trying to just meet the needs of an adolescent. An adolescent wants a tape or a record or money in their pockets to be like other children in their schools and it is the foster parent that more often than not, are reaching into their pocket to provide that.

Why do we keep reaching for group homes? I mean, I understand group homes and there are some everywhere that provide good services and comprehensive services but why do we keep reaching for this alternative instead of paying adequate support to foster parents?

Mr. CHAFFEE. Well, Congressman Miller, you have already hit on it. First of all, as regards group homes, I think we have to openly recognize that for a segment of the children's population, a group home placement is necessary from a variety of standpoints.

Chairman MILLER. Are you talking about a more difficult child?

Mr. CHAFFEE. More difficult child.

Chairman MILLER. Okay, I will grant you that population.

Mr. CHAFFEE. Psychotically disturbed children. But, quite frankly, if you do not have——

Chairman MILLER. But would that—would that be necessarily so if you had support services for that foster parent?

Mr. CHAFFEE. No, that is my next point what you just made. If we could build a constellation of support services for the foster parent at a rate that would enable them to keep that child in the home, there is no doubt in my mind that fewer of these children would go to group homes.

Right now, you have group homes being developed and being developed because of need simply because they can provide the support services, the counseling and other activities that are needed that are not readily available to a foster parent to coordinate all of this. Of course, I think there is some professional frustration in the field among social work staff because if these services are readily available, then the worker can integrate these better for the child than the family but they have to be available in order for the worker to do that.

That requires a tremendous amount of networking and gathering together of resources by the worker. If I may, one big problem that has to be looked at, and I know there is no universal answer to these problems, but certainly, if we are dealing with children, I think we are going to have to get away from some turf issues in fragmenting the child. The fact that the child gets mental health services here, medical service here, child welfare service here and then we expect our social workers to be some kind of renaissance worker that can run out and collectively deal with all of these resources and their turfs in order to benefit that child. There has got to be more thinking about collective networking of these agencies and collective——

Chairman **Miller**. Let me ask you what is going on here. We are in Contra Costa County. We are just in the beginning stages of that effort, looking at the family preservation model. There is resistance but there also seems to be among all of the agencies—probation and mental health and social services—a sigh of relief that maybe this model can work, that in fact, we can make the child or that family the center of the service delivery system. And we have been looking at models—I guess it is in Portland and the State of Maryland and the State of Nebraska. You have more children in Los Angeles than in the two combined, but what these places are showing us is the continuation of the trend that we saw after the enactment of 96-272 that with very intensive intervention with those families who are at risk, by getting in, staying with those families, coordinating those serves, as Gilda pointed out—all of a sudden somebody told you that there is a speech therapist or there is a special education program—we are seeing a decline in both the stay in foster care and the number of children entering foster care. I know you mentioned Home Builders, is that effort being looked at in the counties?

Mr. **Chaffee**. Yeah, I would generally applaud efforts of that type and I guess I would make two or three points there. One, I applaud efforts of that type. I also, where it is not practical to get together for a variety of reasons, size or volume, at least it would be nice if major agencies, say, on the national or state level, had the same priorities. For example, I do not think it does much good to say that children are the highest priority within the child welfare area and then have the highest priority, perhaps in mental health, be the adult homeless. I mean, there has got to be some collateral ability here to deal with what are established priorities. Not that there are not any other priorities. I recognize the homeless situation is terrible but trying to get at the money in these agencies to help children and it becomes almost an impossibility because of the priorities.

But, I would also, without taking up your time, that on a pilot basis where we have been effective is when we have been able to free qualified social workers, children's service workers to work with foster families on an in-depth basis for hard to place children. Ms. Daly mentioned MacLaren Children's Center. We have one social worker out there that has placed extremely hard to place children with foster families and has kept them there. She is the sole worker assigned to these 35 families and the reason she is able to do that is not because she is a miracle worker, she is a very fine worker, but she simply has the time to go around and sit with these families, develop individual resources for them and get back to them on a responsive daily, or every other day, basis. And if it were not for her, we probably would have 35 children that would be in institutions because these children I am talking about are extremely difficult. These are very, very disturbed kids but her involvement has enabled these 35 families to be willing to take those children. That kind of networking we also need more of.

Because if we are not careful now with the funds available, and I do not want to give you cliches, but it can become a mill; juvenile court, the children's services worker, a few minutes spent with each family, you cannot develop foster homes, put them in an institution if that is available or if that is more readily developed and unless there is, I think, some professional expectation for social workers and agencies that they can do some of the professional work they have been trained for, not only will it be a difficult field to recruit for in the future, but your morale and burnout qualities are there all the time. There is nothing worse than setting up a worker to deal and treat with families and not give him or her the resources and the background resources to work with that family.

Chairman **Miller**. Let me ask you a question and tell you that in the hearing the other day in the areas in the States that were able to show some positive trends, most of them had some kind of citizens' review board, citizens' organization, in some cases, specifically just looking at foster care. The argument was being made that some kind of independent review, separate from the establishment if you will, or that which we would legislate in Federal law, Citizens Advisory Committee, that sort of gets absorbed into the system, how—what is going on here in LA with—your mandate is obviously larger than just the foster care but——

Ms. **Daly**. Are you asking me?

Chairman **Miller**. Yes.

Mr. **Chaffee**. Oh, I am sorry. I thought he was looking at me.

Chairman **Miller**. It would be interesting to have both of you answer.

Ms. **Daly**. Well, again, our Commission has been in operation almost four years and I have to say, in the beginning it was difficult. There was a lot of resistance from the Departments to respond to the Commission. There was a lot of, I would call it turf protection and concern about change. I would say that in the three and a half years we have been working together, I think our Commission and the Children's Services Department have come a long way in working together and I think our role with Mr. Chaffee and his Department is to help him get the services he needs for his children. Because the problem in LA County and it exists on a State level and I am sure on a Federal level, is—Mr. Chaffee cannot go to the Department of Mental Health and say I need you to do this for my child. He cannot go to Health Services and say you must do this for the children. He cannot do that. We can help him do that in that we as a Commission can go to those departments and bring attention to the lack of their services to children and try to coordinate—but all we can do, as a Commission, is bring it to the attention of the Board of Supervisors and to the Department heads and try to get from these Department heads what is needed for children. Our need is to constantly keep pressure on and keep it before the public.

I think in order, again for the County to do the job, I think we need the State to do the job because just as fragmented as the County has been, and I believe there has been some minor improvement——

Chairman MILLER. Do you think this will work at the State level? I mean, there is a proposal, right, is there not, in the legislature to do this?

Ms. DALY. There is a Bill that is being heard right now in Sacramento. It is SB-1760, the Senator Torres Bill, to create a commission for children. I—again, as a Commissioner, I cannot take a position on this. Our Commission has not, because the Board of Supervisors has not, so I can just say personally, that the way it is conceived at this point, it may be a start. Again, a commission is not an answer, a department is not an answer but it puts the focus on the need and it puts some pressure on those who are responsible to become accountable to children and to be responsible to children.

Chairman MILLER. I agree with what Ms. Daly has said. I think when the Commission was started, it was controversial, why was there a need for such a group. But I can frankly say that their attention to the needs of children and areas of activity that they have pointed out to the County that need to be looked into have really been outstanding. It does not mean that everything the Commission looks into, the County employees would necessarily agree with but my own personal belief is they have been extremely healthy in an area as sensitive as children. If you have a commission or an oversight or an advisory group available, it probably is enormously helpful and especially in an area where you are working with coordination problems, priority focus. The Commission in Los Angeles, in my opinion, has been extremely beneficial and extremely active. But it only works if the Commission is hard working and this particular Commission has been extremely hard working. It has been not a passive rubber stamp commission and I think that is the key. If you have an active citizens' group that is committed and puts in the hard work the commission has, then I think it does awaken certain people and it does keep you on your toes. If the establishment has it all it's own way, it does get comfortable and it does get in ruts and I am the first one to admit that.

Let me ask you something. Obviously, Los Angeles has been in the spotlight here for the last several months or even longer with the issue of gangs. We had a hearing on gangs in Washington, D.C. and had a young man and a young woman who are gang workers in for the City and County of LA. What do you make of the connection? I mean, to listen to these young people, one was from Philadelphia, in terms of the failures within the families and some of the experiences that these kids have gone—they have gone through that mill in many instances as they described and their friends, of being in out-of-home placement, being constantly moved along and then almost finding a level of permanency in the gang. I mean, it was really frightening the extent to which they would describe the positive attributes of the gang as we would hope they would describe the positive attributes of their family. But they are not, they are describing those attributes to the gangs and they will, in fact tell you, that they have gone through a series of turbulence and all of a sudden, there was one thing that was stable in the whole area—it is not my idea of stability but apparently it was by comparison to their personal lives. I just wanted to—are we running a candidate school with this system? I mean, I get the sense that we are—and I know that is an old saw—that if you do not do it right here, they are going to end up in the criminal justice system and so forth but the more I look at the structure of the gangs and the more I look at the system that is not able to respond, I just wonder if we are spinning out candidates.

Mr. **Chaffee**. Well, it is—I do not pretend to be, you know, an expert on gang activity, per se, but I would say this, that certainly you are right once again. I think the family—the gang becomes the family. It provides the bonding process that is not available to the child elsewhere and that to me is merely a larger argument for getting—if there is one thing in my opinion that will help reduce gang activity, it is either reinforcing the American family or the substitute American family, the foster parent. If we can get centered in child-centered activity with a caring parent and give that parent the resources to deal with the problem, chances are good that you might be able to save that child.

But aside from that, the other forces in society that we all know, what are you going to do with a fantastic drug culture. How are you going to—if you do not cut off the drugs in these areas and do something about the drug culture that is certainly paramount in building gang activity aside from the family bonding that a kid may go through. If you have a 12 or 13 year old kid with $1,000 in his pocket, it is pretty hard to convince him that if he goes to school and the university that someday he may grow up to earn $10 an hour. You know, these are just powerful arguments in the drug culture. So, my answer, from my viewpoint, is I do not know what will happen in gang structure in Los Angeles. The County is terrifically concerned about it. Sheriff Block in this County, as well as Chief of Police, Gates, are maximizing their activities in trying to get at the gang activity as well as support programs for gangs.

Chairman **Miller**. Well, there is no question of that and I was just looking at an amendment in the Senate that is a couple of billion dollars to deal with the end result. I just wonder if we start over here with Wendy and we work our way over here to Nancy, we find that we are running sort of a training program here because you do not need many—because it is interesting, the notion that is popularly presented is the drug connection and its big money, its big drugs, its fast cars, its big guns and all the things. You listen to these young people who testified to our Committee and they went back to very fundamental little notions about their father, about their family, about being moved around, about being Hispanic, about racism. You start out with a couple kids hanging around and pretty soon—and they talked about the evolution of trying to bond with a couple of other kids and then later, that gang being absorbed into the drug operation because you provided manpower, so to speak, for somebody else that was not interested in your background.

Ms. **Lesh**. Could I make a comment on that?

Chairman **Miller**. Okay.

Ms. **Lesh**. Because you have really hit on an area where I feel extremely involved—I am sorry, I am just jumping in my seat here trying to respond. This is one of the major things that we really deal with. All I can emphasize is that in providing services to our families, we have a totally comprehensive family approach, so we do get into these issues with our families as well, (although we are there for the baby). They often have four, five, or six other children who are either pregnant themselves or getting into other kinds of activity. But, it is very hard for a child to bond and to attach to or to feel cared for if the mother is severely depressed. Or if that mother has no hope that her situation is going to get any better and she sees no alternatives to where she is right now.

So, we see children growing up in environments where there is this chronic state of poverty, depression, and lack of hope. They look to any other solution that might provide some of those characteristics for them. I think we really need to look at the family as a unit not just the child. I think the thing that struck me is when Bob spoke, he was saying how all these foster parents, who are competent, capable parents, how much they need resources and how well they are able to function if they get all these additional resources. We are saying our families need that, also! Our mothers, who have these difficult children and who have not been adequately parented themselves need that even more. What are we doing to provide resources for them? So, I really think that we are going back and looking at that pervasive relationship that we have shown—affects outcome. The mother-child relationship starts at birth. How that mother perceives her child has an impact that is carried out throughout that whole relationship and the child's life.

Chairman **Miller**. Well, that is about it, is it not. Let me thank you for your time and for your testimony because I think, in many ways, this gets right down to the crux of the problem in terms of where we, as policymakers, are going to make our decisions on how to spend our money and whether or not we are just going to sort of keep spending on the failures, if you will, or whether or not we are going to invest in some successes. Maybe that has been about as graphically portrayed here by this panel as at any time with the Select Committee and the fact that the story holds true in a County as large as LA as it did by the people from Delaware who testified before the committee a few days ago. They had 600 people in foster care and a crisis on their hands. [Laughter.]

Chairman **Miller**. Yeah, right. The case worker says I will take the 600. [Laughter.]

But the point is, I think, that there too, when they made the decision to invest in the prevention and to invest in again, the least costly but the most efficient means of dealing with it, they were finding successes and I think the fact here that you are telling us that by turning away from almost the obvious now—in terms of the evidence it is the obvious—we are engaging in really just a huge waste of dollars.

So, thank you very, very much and Bob, let me just say to you, this oversight that we are doing with the Ways and Means Committee, at some point, we fully expect to once again engage this

County because I think we have more to learn here in terms of our IV-B, IV-E efforts and the transfers and everything else that is going on there that we will be back to you and would ask you for your help.

Mr. CHAFFEE. Thank you and we would welcome that. Thank you.

Chairman MILLER. Thank you. Thank you very much. [Applause.]

The next panel will be made up of the Honorable Harold Shabo who is a Judge of the Superior Court of the County of Los Angeles, Patricia Nagler who is a staff attorney for the Legal Aid Foundation of Los Angeles, Danny Ramos who is a member of Local 535 SEIU, Supervising Children's Social Worker, Department of Children's Services, Los Angeles, Lillian Johnson who is the Assistant Director of San Francisco City and County Family Children's Services, Judith Nelson who is Executive Director the Children's Bureau, Los Angeles, and Eugene Ferkich who is the coordinator of Student Services, Special Education Division, Los Angeles Unified School District.

Welcome. Again, your written statements will be placed in the record of the Committee and the extent to which you can summarize would be appreciated. The extent to which you want to comment on something that was said by one of the previous panels, that is obviously very helpful to us on the Committee. And even to the extent to which you want to comment on something I said, you may think I am crazier than hell or something, feel free to do that too.

Judge Shabo, we will start with you.

STATEMENT OF HON. HAROLD SHABO, JUDGE, SUPERIOR COURT OF LOS ANGELES COUNTY, LOS ANGELES, CA

Judge SHABO. Thank you Congressman Miller.

Chairman MILLER. Let us make sure your mikes are on so the people can hear you. Yeah, there you go.

Judge SHABO. Good morning. I want to thank the Committee for its invitation to appear this morning. I am not, I want to emphasize, speaking on behalf of the Superior Court of this County nor the Juvenile Court but hope to have some information to offer based upon my two years experience sitting as a Dependency Court judge in downtown Los Angeles, from 1986 to 1988.

Prior to that time, I had been assigned to the Appellate Department of the Superior Court, a much different place from the Dependency Court, for a two year period. Before that, two years in Compton, hearing felony trials, and before that, I was on the Los Angeles Municipal Court for two years.

Chairman MILLER. Now you are going to work——

Judge SHABO. I am now assigned to Pasadena hearing criminal cases again. I just wanted to comment a little bit, if I could, on a statement that Mr. Chaffee made about the need for a constellation of services to assist foster parents in order to avoid institutionalization, and I want to emphasize that the statement I am about to make is not a criticism, per se, of Mr. Chaffee, but he seems to start from a place which is not what the law contemplates.

The law supports, I think as you know, Chairman Miller, that families be together, that families remain intact if reasonable efforts can be made to provide family support and if children are not at risk in the family or not likely to be at risk. If we start with a constellation of services for foster parents who have already gone one step beyond what the Law would require, the law requires that families remain together if possible. Our present emphasis on a constellation of services should be for parents and then for foster parents, if necessary, but not the other way around. It is very nice for Mr. Chaffee to want national recognition of the fine job foster parents do. I, too, applaud what foster parents do. I have seen hundreds, if not thousands of them come through my Court over the last two years. They are extremely dedicated people for the most part. There are some, however, who are in the foster care business for profit and who are not doing any better a job at supervising children in their care than the parents did. Foster parents, on the whole as I said, are highly dedicated people, they go out of their way because they care for kids, to make sure the kids are well cared for.

On the other hand, there is no substitute for home and the Law contemplates the children be home if reasonably possible and if compatible with their safety. We are not, at this time, in my opinion, adhering to the requirements of the Law. Neither the Department of Children's Services, nor the Superior Court in terms of the Dependency Court, is doing a proper and effective job, one, in providing reasonable alternatives to judicial intervention, and secondly, with the Dependency Court, insuring that reasonable services are provided to either maintain families intact or to provide reunification efforts to families or even, in cases of children permanently placed after a 12 or 18 month period in foster care, are we making sure that those children receive the kinds of services that they need.

I should point out, first the Court, the Dependency Court, as the Chair may know, is located in the Criminal Courts Building here in downtown Los Angeles. There are, I believe, three floors of that building partially devoted to hearing dependency cases. There are no adequate facilities. We have approximately 15 courtrooms assigned to hear dependency cases. We have, I believe, four judges assigned full time to hear these cases. People are told to be at Court, I believe by 8:00 in the morning, families. There is no waiting area. They have to wait in hallways with hard benches. They have to drag their kids from all over LA County in order to attend these Court proceedings. Children in foster care or at MacLaren Hall are brought to a shelter care facility on the second floor of that building and are supervised there but must wait there all day long until their cases are called. The Court has made an effort to try and call the cases with sheltered care youngsters early, but that always is not possible.

My caseload in the Dependency Court, sitting in a regular assignment there as one of the four or five judges assigned, at a minimum was approximately 28 cases a day with a maximum upwards of 60. That included detention hearings, arraignments, trials, contested trials, contested disposition hearings, judicial reviews, contested judicial reviews, contested permanency planning hearings, emergency requests for medical relief when a child in foster care had no parent able or willing to give consent for emergency treatment, emergency orders involving runaway children who were apprehended on bench warrants. The place is a mess.

There is not time, because of the caseloads and the lack of adequate judicial resources allocated to the Dependency Court, for families to have their cases heard in an expeditious manner. Some cases are not determined for months or maybe a year or maybe longer at a time. Families come into Court, they wait from 8:00 in the morning maybe until 7:00 at night to have a case heard. Those children sit and wait. The families, as I said, have no place to wait that is comfortable. The kids are forced, since the cases are heard in the Criminal Courts Building, these kids are exposed in the hallways, as are their parents and witnesses, to persons involved in criminal matters. You talked about the gang problem, they have a lot of gang cases in downtown LA. They are exposed to all kinds of people in hallways that are not separated by the nature of the case from Dependency cases. So that is one set of problems.

Before the case even gets to Court, the law requires the Department of Children's Services provide a reasonable effort to insure, through informal means, that families remain intact and that cases not be filed in the Dependency Court. My experience is that the Department, one, either lacks the resources which I find hard to believe because I believe it has a budget of over $340 million, either lacks the resources or passes the buck to the Court. There has been a tremendous rise of public consciousness about child abuse, especially child sexual abuse. Now, with the Steinberg case in New York, physical abuse. On the one hand, there have been the implementation of the child abuse reporting laws, all of these have sort of coalesced to involve the Department of Children's Services in protective service work which, in my experience, almost inevitably, leads to the filing of petitions.

The most difficult kinds of cases that I have seen in terms of a lack of reasonable efforts to avoid filing are the homeless. LA is flooded, as you know, with homeless families, homeless children. The cost of running a court system is great, the cost of filing a petition and the cost of appointing counsel. The cost of processing the paper that goes with the filing of a petition is great. The allocation of resources through the filing of petitions and the things that follow petition filing could much better be spent in public funding for housing, either through DCS funding or Section 8 housing of which we have none. We have huge waiting lists in LA County of poor people who need places to live and that is the only thing that keeps those families separated.

Once a child gets into the dependency system whether as a result or homelessness or for some other reason, we find that the case starts and almost never ends. Children are placed in foster care almost willy-nilly despite the Laws mandate that the need for detention must by urgent and that there must be no reasonable alternative. It seems to me a reasonable alternative would be to order Department of Children's Services to provide funding for housing or to have at least social workers try to help the family find housing. When I have made those orders, the Department comes back and says, one, we do not have the money and, two, we do not have the social worker time.

These kids wind up in foster care. You heard some witnesses earlier talk about the lack of information sharing within the Department. Kids are traumatized by being removed from parents who, but for the fact that they are poor, would be and are good parents, care for their children and love their children. And yet we have a whole group, thousands of children at this point probably, of children who are growing up either in foster care or in institutionalized settings simply for the lack of money for public housing. I think that is criminal.

The way in which the bureaucracy, the bureaucratization of the Department of Children's Services has grown, there has been an expansion at the top with a depletion of field worker support at the bottom. Field workers, CSW's in the Protective Services side of DCS, tell me that they have caseloads from 70 children up to a hundred, that they have time only to respond to emergencies. That—I cannot tell you the number of cases but it is quite substantial in which I have made orders for mentally disturbed children to receive psychiatric care while in MacLaren Hall and no care was provided. I had a nine year old girl who had been raped by her drunk father in a grandmother's house on the day—I think it was her birthday. She testified before me. I found the petition to be true. She was obviously mentally ill at that point, certainly emotionally disturbed. I am not a psychiatrist so I cannot make those diagnoses but I ordered that while she was at MacLaren Hall, pending a disposition hearing, she receive on-going psychological counseling with someone experienced in the area of sexual abuse. The case had to be continued a couple of times, probably over a two-month period because the father did not come back to Court for the disposition hearing the first time. The second time we proceeded without him.

On inquiring, at the time of disposition hearing, who she was seeing for counseling, it turned out the social worker either did not read or forgot to implement the Court's order for counseling for that girl. That is not an isolated case. That is a regular and predictable response of Children's Services to Court orders simply because of caseload.

The other side of it is their claim of lack of resources. It is true, we do not have adequately funded community based resources in LA County. In the area of drug abuse, as nationally I believe, people who are seeking help with drug abuse problems are placed on waiting lists for months at a time. If they are poor people, which most of our people in the Dependency Court are and unable to pay for a private program, we made referrals to low-income—we order DCS to make referrals to low-income programs. There exists an insufficient number of insufficient programs. We order DCS to assist in the payment for drug testing and for enrollment in these programs. DCS comes back and says we do not have the money for that. The most we can do is supply a bus pass for these parents. These parents have to pay for their own drug testing, have to pay for their own program, have to visit their kids in foster placement which is another problem because foster placement in LA County means that a parent may live in south central LA and yet the foster placement is in Lancaster which is in the north part of the County, probably 60 miles away. We have miserable public transportation in LA County. We have impoverished parents. We have people who do not have the ability to get to a drug program and do testing. How are they supposed to visit their kids? Sometimes foster parents are kind enough to meet the parents halfway or even drive into the parents neighborhood but how can you ask foster parents to do that on a regular basis. It is enough that they are not getting enough money or support of the children, that they are not even getting money on time. Some of them have to wait a month—excuse me, not a month, 6 months, 8 months, 9 months, sometimes longer with the social workers sometimes telling relatives who are foster care takers not even to bother to apply simply because the social worker does not want to fill out the forms.

We have developed a system which is like a large funnel drawing in all kinds of kids with all kinds of different problems from problems of homelessness alone to severe problems of sexual abuse. The Court is not adequately staffed to deal with these problems. DCS, apparently, is not adequately staffed to deal with these kids and so the ones with the most serious problems are the most neglected and the ones with the least serious problems for whom there are readily available alternatives to DCS and Court intervention, get swallowed up in the system and become part of the parentless generation that we are raising.

Chairman **Miller**. Thank you.

Judge **Shabo**. Thank you. I was asked to limit my remarks. I could go on for a few more hours.

PREPARED STATEMENT OF HAROLD E. SHABO, JUDGE OF THE SUPERIOR COURT OF CALIFORNIA, LOS ANGELES COUNTY, LOS ANGELES, CA

Mr. Chairman and Members of the House Select Committee on Children, Youth and Families, I wish to take this opportunity to express my thanks for your invitation to testify this morning before you.

I appear this morning out of a deep sense of concern for the state of the dependency "system" in Los Angeles County and the manner in which it treats the children and families coming to the system's attention. By "system", I mean the Department of Childrens Services, its Division of Adoptions, and the Dependency Court itself. I believe that in terms of caseload, lack of services, and a lack of commitment of adequate judicial resources, the dependency "system" itself is engaged in a pattern of neglect and abuse of the children and their families, and the "system" is at such a point of overload that the needs of children and families are not being met in too many cases. In this connection, I wish to emphasize that I am offering only my personal viewpoint based upon two years experience as a judge in the Dependency Court and that I do not speak for the Juvenile Court, for the Superior Court in Los Angeles County nor for anyone else. My personal viewpoint, however, is based on two very difficult years presiding over dependency proceedings in thousands of cases.

I have had only a short time to prepare my written testimony and my oral remarks. Thus, I cannot and do not represent to you that my remarks purport to be inclusive of all problem areas of the dependency system. Rather, I wish to focus on some "bottom lines."

First, I wish to point out that the dependency system in Los Angeles County is not doing its job. That job entails following legal mandates to make "reasonable efforts" to avoid the necessity of Juvenile Court intervention and the necessity of removing children from their homes if compatible with safety. That job also includes, in cases involving court intervention, providing in most cases reasonable reunification services within a legally mandated period of time. Unfortunately, I must report to you that in Los Angeles County, at least, "reasonable efforts" to avoid the need for court intervention in too many cases and "reasonable reunification services" do not exist. For example, in the case of homeless families, it seems to me that "reasonable efforts" to prevent or eliminate the need to remove a child from parental custody should include access to public housing or, in the alternative, to public funding through Department of Childrens Services, in order to pay for the housing of families without resources. Yet I have arraigned an overwhelming number of cases in which the basis of the dependency court petition was "Child Neglect", the factual predicate of the allegation being that the family is simply homeless. It is clear in these cases that the parent or parents both love and want their children. The only basis for detaining the children, placing them in shelter care facilities, and, of course, dividing families is the parent's inability to obtain shelter. The laws mandate for "reasonable efforts" should logically require that public funds be made available for the purpose of securing the family shelter. Nonetheless, the Department of Children Services detains the children and divides the family, and in answer to a court order to provide funds for housing or assist the family in finding housing, the Department claims that it lacks the funds and that social workers lack the time to assist families. We know that through budgetary cutbacks, at the federal level, funds for public housing through Section Eight are severely limited and that Section Eight housing is unavailable. Nonetheless, the lack of public funding, under Section Eight, results in literally thousands of children being placed in shelter care for prolonged periods of time and sometimes permanently. The cost to the taxpayer in terms of court time, foster care payments and Department of Childrens Services resources, I am sure, far exceeds the cost of providing public funding for adequate housing for these children and their families.

Certainly, the lack of public funding for housing flies in the face of the law's policy of attempting to keep families together by providing "reasonable efforts" to prevent the need for judicial intervention.

Another example lies in the overwhelming number of drug abuse cases brought to the Dependency Court's attention. Whether the issue is one of detention or providing "reasonable reunification services", the impact upon families and children for the lack of available drug abuse programs in Los Angeles County able and willing to treat indigent and low income parents is shameful. In this connection, I must note that in my personal experience newborn babies born in public hospitals, of a drug abusing parent, seem automatically to be detained and placed in shelter care facilities, whether or not the newborn is at the time of birth suffering from drug withdrawal symptoms and whether or not the newborn requires special care. Lack of adequate drug abuse treatment programs available to the drug abusing parent results in the newborn spending its early formative period in a stranger's home or institutional setting and a consequent lack of bonding with the parent. The result is that after a six to twelve month so-called period of reunification, the Department of Childrens Services often recommends that the baby be referred for adoptive planning or permanent placement services, with the result that the child will spend many years waiting to be adopted and will not be raised by its natural parent. It is of interest to note that I can recall no case of "drug" babies born under the influence of drugs or suffering drug withdrawal symptoms, who were the babies of wealthy or middle class parents receiving private medical care. When drug abuse permeates our entire society, I must wonder why no babies born of affluent families come to the court's attention in such cases. That my observation is not unique is borne out by recent newspaper articles which have reported that private medical providers do not seem to adhere to the requirements of the Child Abuse Reporting Law in the area of drug abuse by parents.

From the foregoing examples, I think it clear that the dependency system is ignoring legal mandates designed to keep families together or to reunite them at the earliest possible time. The examples highlight graphically the devastating effects upon families who, because of poverty, are essentially destroyed by a system which is itself inadequately funded, and by a society which lacks the commitment to provide adequate community-based resources in order to accomplish the Dependency Law's mandate.

A second "bottom line" concern is the caseload of Department of Childrens Services caseworkers, who are supposed to provide reunification services and permanent placement services for children. CSW's have reported to me caseloads ranging from betwen 70 to 100 children per worker. Obviously, the children coming into the "dependency system" need special care and attention. Many are physically or mentally handicapped or both. Many are highly traumatized either by the abuse or neglect which they suffered in their families or by their abrupt removal from their family by agents of the state. As caseworkers have reported to me, consistently, they simply lack the time and financial resources to attend to the needs of these children. They report to me that with their excessive caseloads, workers are only able to respond to emergencies. Even in cases in which the court makes special orders for psychological or medical care, these orders are regularly ignored, sometimes for months, by the Department of Childrens Services. For example, after hearing an adjudication involving an alleged act of sexual abuse by a drunk father against his nine-year old daughter, who was an extremely emotionally disturbed child, I ordered that the child, who was detained at Mac Laren Hall pending a disposition hearing, receive immediate sexual abuse counseling. At the time of the disposition hearing, two months later, I found that she had not received such counseling because the CSW had either not read or had forgotten the court's order.

The case of children with special needs, such as developmental delay or deafness, also go largely unmet. For example, in the case of children suffering from mental retardation, the court frequently has to do the social worker's job in ordering that the child be referred to the Regional Center for special services. Such court-ordered referrals occur long after an adjudication and disposition hearing. Often, I have had to make these orders when the case comes up for permanency planning hearing or judicial review years after the child had been declared a dependent child of the court. Beyond this problem, is the inadequacy of the Regional Center services, as reported to me by CSWs. I have been informed on a regular basis that after accepting a case, the Regional Center "drops the ball" in failing to follow through in attending to the special needs of developmentally delayed children for training, education, and psychological services. Finally, the services offered to children, who are clients of the Regional Center, vary as to quality and availability, depending upon the Regional Center which happens to serve the geographical area in which the child resides.

In the case of deaf children, I have had several who have come before me who were long before declared dependents of the court. There exists in Los Angeles County no specialized foster home to cater to the needs of these children nor any special educational facility able to take children who also happen to be developmentally delayed or whose behavior is deemed to be less than optimal. In the case of a teenager, named Michael, who had several years earlier been declared to be a dependent child of the court and had been detained at Mac Laren Hall after being excluded from the Riverside School for the Deaf, which he attended for several years, I ordered that pending his placement he receive the services of a deaf interpreter so that he could attend school at Mac Laren Hall and that his case be assigned to a worker trained to communicate in sign language with him. Michael remained in Mac Laren Hall for several months, the Department of Children Services claiming it had no foster home for him because of Michael's "assaultive" behavior. Though Michael was also a client of the Regional

Center, that agency could offer no specialized placement for him. Moreover, the Department of Childrens Services largely ignored repeated court orders that Michael receive the ongoing services of an interpreter for the deaf and psychological counseling. When, as the result of teasing by another child at Mac Laren Hall, Michael reacted in an assaultive manner, a delinquency petition was filed against him and Michael was shipped off to Napa State Hospital, a mental hospital in Northern California, which also provides services for the deaf. The Department of Childrens Services then requested that the dependency proceeding be dismissed, a request I have consistently refused.

It is plain, from the case of Michael and numerous other children with special needs, that the Department of Childrens Services is guilty of gross neglect of these children. Even when the court orders specialized services be provided, the Department ignore the orders. Cases of CSWs "laughing" at court orders for specialized care which I have made have been reported to me from time to time.

A third "bottom line" which concerns me is the bureaucratization and consequent inflexibility of the Department of Childrens Services. Apart from the fact that the Department's record of filing reports with the court on time is abysmal and regularly accounts for at least a third of a daily calendar of the court having to be continued for lack of a report being filed, the Department is locked into a rigid, bureaucratic mind-set which deprives children and their families of the services to which they are entitled under law. A case which readily comes to mind involves two young Egyptian children, Samuel and Marlene, whose mother had tragically died. At a hearing early in 1987, their father and the children appeared before me. The father indicated that he no longer wished the children and wished them placed with their aunt. The children were placed with the aunt and I set an early review hearing for May 8. The DCS report for that date did not indicate the aunt's intentions with respect to keeping Samuel and Marlene and so I continued the case for further report to July 2, setting that date as a permanency planning hearing date. In a supplemental report, filed for the July 2 date, DCS reported that the aunt could keep the children only temporarily, that she herself had two children and was a widow, and she was on welfare and planned to leave Los Angeles County within a few short months. I immediately ordered the children be referred to adoptive planning and further ordered that the children receive ongoing psychological counseling. In the July 2 hearing, the aunt said she wished the children adopted by people of the Coptic religion. I appointed the Child Advocate's Office to assist the children and the aunt in the hope that that office could find such a family. The Child Advocate's Office immediately assigned someone to assist. On July 2 I continued the case for judicial review to December 31.

On December 31, expecting to receive a report from the Division of Adoptions of the Department of Childrens Services, I instead received a report from the Treatment Section of the Department of Childrens Services, the report purportedly signed by the original CSW on the case and her supervisor. The report indicated that due to an administrative "glitch," Samuel and Marlene's case had never been assigned to the Division of Adoptions. I immediately ordered the social worker, her supervisor, and the head of the Adoptions Division into my court, since it was clear from letters by therapists, attached to the judicial review report for December 31, that DCS had not done anything to implement the court's orders with respect to immediate adoptive planning and since it was further clear that the children's aunt could not keep the children any longer. In addition, I had received a report from the Child Advocate's Office that during the preceding six months period, two perspective adoptive families had been located by the Child Advocate but that these families no longer desired to adopt Samuel and Marlene because of the administrative delay in the case.

At the hearing on December 31 the CSW's supervisor admitted that she had signed the social worker's name to the report, that the social worker had not been assigned to the case for several months, having been transferred to another unit, and that she had effectively done nothing to provide services to the children nor to effectuate the court's order regarding adoptive planning. Despite the exigencies in this case, the CSW supervisor did nothing to effectuate the court's order. As the Guardian Ad Litem's representative stated in court on December 31: "At the six months review the court ordered the case to be transferred to the Division of Adoptions. That hasn't taken place during the last six months. The aunt has discovered many families willing to adopt children, except, she wasn't able to get hold of the case worker or _________ __________ and these options are no more available, just that the families couldn't wait around."

I have with me a transcript of the hearing in the foregoing case held on December 31, 1987 and believe it would be of much interest to this Committee. However, under State law the transcript and records of the case of Samuel and Marlene are confidential and records cannot be released without prior order of the Juvenile Court. If the Committee wishes to obtain such an order from the Presiding Judge of the Juvenile Court, I would be happy to supply a copy of the transcript and any other records which the Committee might desire.

The foregoing case illustrates the fact that there is little or no communication between the Adoptions Division of Department of Childrens Services and the Services component of the Department. Frequently, I have seen cases in which dependent children, who are the subject of reunification or family maintenance services, are separated from other siblings who are receiving services under the Adoptions Division. Reports to the court from the Adoption Division as to these siblings frequently contain outdated information concerning the parents and often, for example, reflect the parents' whereabouts as unknown. At the same time, the court will see judicial review reports concerning the siblings and parents from the reunification and permanency placement services section of DCS, which reports reflect that the parents' whereabouts are known and will contain up-to-date information concerning their ability to care for the siblings. In many instances, I have returned children, who are the subject of a recommendation for adoptive placement services, to parents raising siblings in their own home where it is clear from the social worker's report that the parents are doing a good job in raising the siblings. Nonetheless, the adoptions reports will indicate no current information on the fitness of the parents or their whereabouts. Last year, in fact, I had a case in which the mother was being supervised in Washington State, was raising dependent children in her home, and was reportedly doing well. Nonetheless, the Adoptions Division reported, concerning a younger child referred earlier for adoptive planning, that the mother's whereabouts were unknown, that she was a prostitute and a drug addict--facts refuted by the Washington State report submitted by the services component of DCS. As a judge, I found it particularly difficult to

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decide critical issues, such as the future of a child, based upon such reports because they were so often unreliable.

A final "bottom line" lies in the Dependency Court's inability to deal with its current caseload in a fashion which expeditiously adjudicates and disposes of cases coming before it. In the first place, the families coming before the court are generally indigent and from various minority groups. It is not a frequent occurrence to find an affluent family before the court and certainly not for a prolonged period of time. The court is located in downtown Los Angeles in a centralized location, which makes it particularly difficult for parents who are poor to come to court from outlying areas. The court is located in the Criminal Courts Building--a particularly unfortunate fact for families who have been traumatized and who need to remain in hallways from 8:00 in the morning until 6 or 7 o'clock at night, mingling with witnesses, victims and defendants in criminal cases.

Moreover, the court itself devotes insufficient judicial manpower to the handling of its caseload. In my own court, over a two year period, I would on the average handle a minimum of 28 cases and sometimes as high as 70 cases per day. Such a caseload included arraignments on new cases, detention hearings, contested adjudications and dispositions, judicial reviews and permanency planning hearings, as well as emergency matters which regularly surfaced. The sheer volume of cases on a daily basis precludes effective decision making in dealing with what are the most delicate, sensitive types of cases to come before a court. To deal with the masses of people, and paper, is a superhuman job for any bench officer. To make wise, correct decisions involving the future of children, under these circumstances, is an impossible job. At the present time there are 15 courtrooms devoted to hearing dependency cases in Los Angeles County. These courtrooms are staffed by seven judges, five commissioners, and a variety of referees. Although, in mid-1987, the court instituted a direct-calendaring system by which each department is responsible for cases from the beginning through permanency planning hearing in order to insure accountability by the Department of Children Services and families in adhering to court orders, the fact is that the sheer volume of caseload makes it impossible for the courts to accomplish the goal of accountability. Families crowd the hallways of the Criminal Courts Building from early morning to late at night; children are transported to and from court and spend the entire day waiting for their cases to be heard. When called, the cases are often continued or given a short shrift given the volume of cases which the court must process daily. Contested hearings are accomplished piecemeal and are often continued for months at a time in mid-trial before issues can finally be determined. I've had several cases which have taken many months, sometimes a year or more, finally, to conclude. In the meantime, children in foster care in such cases are deprived of their right to a speedy determination and to be returned to their parents if appropriate. There simply isn't time speedily to conclude the cases, as mandated by the Dependency Law.

At the present time the Superior Court is faced with a law suit in the federal court brought by the civil trial bar and joined in by the American Civil Liberties Union. The suit alleges that an insufficient number of judges are assigned to hear criminal matters, which has resulted in an alleged backlog of civil cases and unwarranted, prolonged detention of persons charged with crime. However, laudable the law suit, the merits of which I will not comment on, the fact is that the law suit has put pressure on the court to assign more judges to criminal matters. At the same time, the Dependency Court is inundated, as I have indicated, with no apparent indication that additional courts and bench officers will be assigned to hear these cases. With the Child Abuse Reporting Laws and public consciousness concerning child abuse bringing before the court an increasingly larger caseload, it is unfortunately likely that conditions which are now critically bad will only get worse.

We must face the fact that the Dependency Court and DCS are not doing their job. Until governments on all levels are willing to make a commitment to provide adequate services through properly administered, community-based resources and to furnish and sufficient judicial resources to protect our children, we will perpetuate a system which in itself is cruel and neglectful of families and children.

Thank you for your attention to these remarks.

Chairman **Miller**. I get the sense of that. I do not know if I could take it.

Pat Nagler.

STATEMENT OF PATRICIA NAGLER, STAFF ATTORNEY, LEGAL AID FOUNDATION, LOS ANGELES, CA; ACCOMPANIED BY BYRON GROSS

Ms. **Nagler**. Good morning. Thank you for inviting me to speak today.

Chairman **Miller**. You have a microphone there. Can you hear in the back? I am sorry.

Ms. **Nagler**. Thanks. Good morning, Mr. Chairman. Thank you for inviting me here to speak to you today. I am going to address the issues of the failure of the system to provide government benefits and preventative and reunification services to children in the foster care and dependency system.

Byron Gross, on my left, is going to describe the problems encountered by homeless families.

Judge Shabo has done an excellent job of outlining the problem and I am going to try to fill in some of the more intricate parts of the government benefits problems. I first became involved in working with foster children when I was retained by a client who was attempting to obtain AFDC foster care benefits for her two grandchildren. Initially, she had been told she could not get foster care benefits for them and instead would only be eligible to receive basic Federal AFDC. The basic AFDC grant amounts were substantially lower. In this case, the basic AFDC grant was between $125 and $175 lower than the AFDC-foster care benefits.

When she finally discovered that she could get foster care benefits and approached me for assistance, I thought it would be an easy job. I expected it to take me a week or two weeks to solve this problem. Over a year later, we finally got her the first payments. Then she started to experience delays in the receipt of subsequent monthly payments.

Her grandchildren also had psychological problems because of the abuse that they experienced while living with their mother, who was a drug addict. Again, I thought this would be an easy problem to solve because I read California's SB-14 legislation and the Federal legislation, 96-272, both of which are wonderful. I thought, no problem, I am going to get Mental Health services for these children. Again, it was a constant struggle which took months to resolve after, I intervened.

When I started working with this client, it was like opening up a hornet's nest. There were so many problems we did not know where to begin. We started to try to focus our energies, first, on the AFDC foster care payment system. We noticed that, number one, relatives were never told about the availability of these benefits and two, the benefits were delayed substantially. We began to do outreach to foster parent associations which are primarily made up of foster parents who are unrelated to the children. We found that these unrelated foster parents were experiencing the very same delays as related foster parents. They have even organized against the Department of Children's Services to say that foster parents will stop accepting children into their homes if they are not paid on time.

Now, I know that Los Angeles County is trying to address the problem but it is too little too late. Despite the excellent provisions of the Adoption Assistance and Child Welfare Act, it just is not working, partly because it is not adequately funded either by the Federal or State or local governments and partly because it is not adequately enforced by those very same government agencies.

We have met numerous times with officials at the Los Angeles Department of Children's Services in order to work through some of these problems and although I think they are well meaning people, particularly at the field level, it is fruitless. The solution to the problem is not just more money, though we certainly need that to provide adequate services. We also need the affected agencies to use that money creatively to provide home based preventive services.

In Stanislaus County and in Solano County, they are actively working in that direction and that is where they are devoting a large percentage of their money. That is what we need to start doing in Los Angeles County.

I would like to present a case example that I think graphically shows the problem when you do not provide preventative services. As Judge Shabo was saying, social workers typically have case loads that range from 60 to 80 cases. In one such situation, a toddler who had been abused by an unknown perpetrator was allowed to remain in the home of his mother. His social worker, as is typical among Department of Children's Services workers, had a—I am really having trouble here. I took some medication.

Chairman **Miller**. That is all right. Why do you not wait and we will get some water here.

Ms. **Nagler**. Okay, thank you. I apologize.

[Pause.]

Ms. **Nagler**. I could go on.

Chairman **Miller**. Whatever you are comfortable doing.

Ms. **Nagler**. Okay.

Chairman **Miller**. Our apologies for not having some water there.

Ms. **Nagler**. No, it is really—I took some medication this morning and it is affecting me.

The social worker had a case load close to 70 children. Even the most diligent social worker cannot provide proper preventative services to a family with that many children in her case load. Despite a State regulation that requires that social workers make monthly visits to the parents and child, the CSW had not seen this child for over four months, when the Court terminated jurisdiction. I better wait for the water.

Chairman **Miller**. Why do we not go on to the next witness and we will come back to you. Is that all right?

Ms. **Nagler**. Sure.

Chairman **Miller**. That will, I think, make it easier. Mr. Ramos.

Ms. **Nagler**. Mr. Gross was going to come next.

Chairman **Miller**. Oh, excuse me. I am sorry, yes. I am sorry, Mr. Gross.

STATEMENT OF BYRON GROSS, DIRECTING ATTORNEY, LEGAL AID FOUNDATION OF LOS ANGELES, LOS ANGELES, CA

Mr. GROSS. Thank you, Mr. Chairman. I want to make some brief remarks about some recent legislation in California which goes a considerable way towards dealing with the homeless family crisis. I will resist the temptation to describe in detail what is going on out there in regard to homelessness because I am sure you are quite aware of it. I know you have had at least one hearing just devoted to the subject of the effect of homelessness on children and families and furthermore, I could not be as graphically dramatic as the recent series of TV movies has been. Network television may have brought us Leave it to Beaver, as a prior speaker mentioned, but it also brought us God Bless the Child and really brought the message of what is happening to homeless families, to America.

The legislation that has so recently come into effect is AB-1733 which was sponsored by Assemblyman Isenberg of Sacramento, which was a response to pressure brought by a court order that we obtained ordering the State to provide emergency shelter to homeless families. It is unfortunate that we had to resort to litigation to get this result but unfortunately, that is often the case.

What this legislation did was add to the AFDC program a new non-recurring special need for homeless assistance. This homeless assistance takes two forms; it provides temporary shelter and it provides assistance for families to get into permanent housing. Under the legislation, a homeless family can immediately receive $30 per day for emergency shelter when walking into a welfare office and declaring themselves homeless. This temporary shelter can last for three weeks and, for good cause, for a fourth week.

During this period, the family should be searching for permanent shelter and if they are successful in locating an apartment or house, then the Welfare Department will provide funds to pay for the security deposit necessary to move in and also for any utility deposits which are necessary for utility hook-ups.

These new benefits just went into effect on February 1st of this year, just two months ago and there is already a dramatic change. One afternoon last week when I was on emergency intake in my office, I spoke with three families who benefited from this legislation. One family was newly homeless and was going for emergency benefits, but the other two had already obtained permanent shelter and moved into a permanent apartment with the help of the security deposit money from the Welfare Department. Without this money, they would never have been able to do that. They would have been drifting from motel to motel, from shelter to shelter and the children would have been out of school and suffering.

Preliminary figures from the LA County Welfare Department indicate that approximately 1,000 families have benefited from this new legislation in the first six weeks alone of the program. I do not want to mislead you into saying that this is a be-all and end-all to the problem of homelessness because obviously the problem of homelessness among families runs deep. Many of the families need support to get back into the mainstream and, of course, there is the problem of low-income housing that Judge Shabo mentioned which is the overriding cause. But, at a minimum, there must be this kind of financial back-up available to enable families to get back into permanent housing before homelessness does them in and renders the family dysfunctional. This is just another example of the prevention being cheaper than the cure. It is much cheaper to give a family $800 for a last month rent and security deposit and get them back into the mainstream than have them drifting homeless, have the family become dysfunctional, end up in the Juvenile Court system, end up in the Children's Services system which is incredibly expensive. This new legislation was a bipartisan solution to the homeless family crisis. It was supported by advocates for the homeless throughout the State. It was supported by the State Legislature and supported by the Republican Administration in California.

Nonetheless, this legislation almost did not go into effect because the U.S. Department of Health and Human Services was going to deny California' request to amend its State Plan Amendment to provide for these benefits. Because these are done through the AFDC program, the Federal government must pay half the share and the legislation stated that the benefits would not go into effect if the Federal government did not pay its share.

For absolutely no substantive, or rational reason, HHS denied California's request for these benefits. After all the hard work and after all the hopes that we had for this legislation, we were flabbergasted and, frankly, we were outraged that HHS was going to deny these benefits which were so needed. Furthermore, it seemed a direct slap in the face of Congress, which just weeks before had passed a provision acknowledging the homeless family crisis and directing HHS to continue to pay special needs benefits that states were requesting for homeless families.

Fortunately, due to pressure put on by Congress, HHS relented and reversed their position, but not until the last minute. It was 3 days before the legislation was going to go into effect that they approved it. Although they have approved it, and this is important, they have only approved it through October lst of this year. If Congress does not keep its eye on what HHS is doing with this program, these innovative and needed benefits may not be in effect after October lst of this year. We will be back where we were before, with families unable to find housing, drifting from temporary shelter to hotel to the streets and back into these other systems which are so much more expensive.

So, I am urging you to keep your eye on this issue and to consider this as model legislation which could be copied throughout the country and used in other states to prevent and modify homelessness—to prevent HHS from denying the states the right to establish such programs in their jurisdiction.

[Prepared statement of Byron Gross follows:]

PREPARED STATEMENT OF BYRON J. GROSS, DIRECTING ATTORNEY, GOVERNMENT BENEFITS UNIT, LEGAL AID FOUNDATION OF LOS ANGELES, LOS ANGELES, CA

Our Legal Aid program has assisted literally hundreds of homeless families as they have attempted to work their way through the bureaucratic maze of the welfare system. As a result of litigation against the State of California to demand emergency shelter for homeless families, we now have new homeless assistance benefits, funded through the AFDC program, which provide for temporary shelter and permanent housing assistance. These new benefits should be looked at as a model for other states, and Congress should assure that HHS continues to permit states to provide these benefits. This testimony will include a description of the homeless family crisis as we have seen it and a description of our recent state legislation which attempts to address the crisis.

The Developing Crisis of Homeless Families in Los Angeles: From the Shadows to the Urban Campground and Back into the Shadows Again

For years, the problem of "homelessness" was seen by most as a problem of what to do about sad, alcoholic men and crazy bag ladies who were sleeping in doorways in our cities' Skid Rows. There were a few social service providers who were concerned with families with children who were homeless, but, for the most part, these families were invisible. Families don't line up waiting for a place at the mission, and homeless families often are reluctant to seek assistance from government social service agencies for fear that their children will be taken away from them. In the years from 1985 to 1987, as the homelessness crisis exploded into what it is today, it became increasingly evident that there are a large number of families with children who are part of the homeless population. Now, with several TV movies in recent weeks describing the plight of homeless families, the fact that there are thousands and thousands of children living in cars, parks, shelters and rat-infested hotel rooms has finally been etched indelibly on America's consciousness (and, hopefully, on America's conscience as well).

For those of us providing legal services and social services to poor persons in Los Angeles, the reality of the homeless family situation became permanently and painfully obvious during the summer of 1987 with the urban encampment on the Eastside of downtown. In June, 1987, the City of Los Angeles was attempting to clear the streets downtown of the large number of homeless persons who had congregated there and had set up small tent cities on the sidewalks. These were, for the most part, single adults, not families, who were shut out of the County's General Relief Program or, even with the meager General Relief allotment, unable to afford housing. Meeting resistance from homeless activists for its heartless bulldozing of these encampments, the City decided to temporarily allow homeless persons to stay in a dusty, vacant lot down by the railroad tracks. The City contracted with the Salvation Army to manage the facility, which consisted of canvas cots under canvas canopies, portable toilets, a few picnic tables and some showers.

Although intended for the adults who were living on Skid Row streets, the urban campground became a desperate refuge for families with children as well. At one time, there were about 70 families among the 600 residents of the camp. It was a horrible and dangerous and unhealthful place for children. A few of the families had separate tents which they had set up, but, for the most part, the families were living along with everyone else, basically out in the open air on army cots lined side by side. Many of the children were filthy, an almost unavoidable consequence of living in the brown dust which was everywhere. Stagnant puddles of water attracted insects. The Salvation Army served dinner, but often that was the only meal available. Sometimes, some volunteers provided cereal for the kids in the morning. These children were exposed to unsanitary conditions, hunger, and the danger of being thrown together with adults, many of whom were mentally ill.

For me, it was the sight of the children in that dusty nightmare which forced me to really accept the staggering magnitude of the problem. No parent would allow their child to spend even one night in that dreadful environment if there were any possible alternative. Some of those families remain vivid in my memory, almost a year later. There was the woman in a wheelchair, just arrived from Louisiana with her 3 children.

There was the mother and father with 6 children. Three of the kids were huddled together under a blanket on two cots pushed together. The mother was frying some fish over a tiny barbecue. The youngest child, about 3 years old, was covered with sores on his arms and legs. This family was in the camp for 3 months. They were receiving AFDC, but they just couldn't save enough money to put down on an apartment -- their money kept going for car repairs so they could get out of the camp to househunt. Once they got their transportation going, they couldn't find a landlord who was willing to rent to a family with six kids.

Another family I remember was a woman from the Norwalk area with her 11 year old son. The welfare department had delayed her check and sent her, without funds, down to the campground. Now, she didn't have enough money for gas to get back to the welfare office to pick up her check. She had recently lost her job, but was planning to apply for an electronics assembly job which she had heard about. She thought that she would be working within a week or so. She was quite upset about exposing her son to the unpleasantness of the camp, but was well spoken and seemed able to cope. I saw her again, at the camp, 3 weeks later. She was a totally changed person. She was dishevelled, she kept bursting into tears, she was angry and directed some of her hostility at me. Her son was standing there with her, with the most forlorn look imaginable on his face; watching his mother change like that must have been devastating. It was a vivid picture of how homelessness can destroy the spirit.

Since the urban encampment was closed by the City in September, 1987, there is no longer a large, visible group of homeless families in one place. Once again, they are spread throughout the city, in their cars, in shelters, waiting endlessly in welfare offices. Recently, I spent an afternoon doing advocacy in one of the local welfare offices. Among the people there, I met a woman who had recently arrived with her husband from Delaware. Since her husband had lost his job there and couldn't find new employment, they decided to come to Los Angeles where he had grown up. She had a 7 year old son and a month-old infant; they had traveled by bus across the country when the infant was one week old! They were staying with the husband's mother in a housing project, but they were crowded in and unwelcome and the "hospitality" was about to end. At least they had each other, and the husband was out looking for work. The welfare department was giving them the run-around. The woman had been there, waiting all day, for three days in a row, with nothing to show for it. Each day, she had to walk 2 miles to the welfare office, with her infant and her 7-year-old. After I assisted her, the welfare department finally gave her a small check and some food stamps. But, it wasn't enough to escape from the temporary quarters at the housing project. By the next time she called me, the stress of their situation had led to her husband physically battering her. Now, she was asking me to help her find a shelter for her and her kids to escape. Homelessness had done in their once happy family.

These are just a few of the many homeless families who have crossed my path in my work with the welfare system. This testimony will focus on some ideas for getting these families out of their miserable situation and into temporary, then permanent, shelter. This will not be a complete solution to these families' problems. The causes of homelessness run deep, and some of these families may need ongoing support to permanently break the downward spiral of their lives. But the first step must be getting them off of the street and into some shelter.

How the Welfare System has Historically Helped Homeless Families in California

Until recently, the State of California and Los Angeles County have dealt with the need for emergency shelter by families in a much different way than the need for emergency shelter by single adults. Under Los Angeles County's General Relief program, homeless adults without children, even if they don't have identification, can theoretically walk into any welfare office and will receive a voucher for a hotel room that night. The emergency shelter in a hotel will continue until their General Relief grant is approved.

By contrast, for families, there was no emergency shelter available. Under the AFDC program, families could receive only $100 as an emergency payment, and the Department of Public Social Services (DPSS) is not required to provide this "Immediate Need" payment until the day after the family applies. This $100 had to last until the case was approved, a process which could take several weeks. Nothing in federal law required any more than that. Federal law did provide Emergency Assistance (EA) money which states could choose to use for emergency shelter; California, however, has not chosen to use its EA money in this way.

Separate from DPSS, which administers the AFDC program and other welfare programs, Los Angeles County's Department of Children's Services (DCS) is supposed to guard the welfare of children and help to keep families together. However, DCS provides no emergency shelter to families, although in some cases it may remove the children from the parent(s), place them in McLaren Hall or in emergency foster care, and let the parent(s) fend for themselves.

Homeless families had to rely on private, non-profit shelters to get emergency help, but the private shelter system can nowhere near meet the need. In 1986, Infoline, Los Angeles County's Referral Agency, was unable to find emergency shelter referrals for 40% of those persons requesting shelter. That percentage is growing every year (it was 25% in 1985). Even those families who could get into emergency shelters often had to wait days or weeks for an opening.

The inadequacies of the system to assist families to escape from homelessness became painfully evident last summer while we were trying to help families leave the urban campground and transition into housing. A Skid Row social service agency called Para Los Nincs worked hard to get the families out, but it was no easy task. Many of the families in the camp were receiving AFDC, but AFDC checks were not enough. If they took their check and paid for a hotel room, there would not be enough left for the high cost of food when you don't have a kitchen, let alone for transportation to look for more permanent housing or for the high move-in costs to get an apartment. Fortunately, there was some federal money available (through FEMA) for emergency hotel vouchers, but these only lasted two weeks and then many families were right back in the camp again.

The failure of the federal government, the state or the counties to make any provision for emergency shelter for families, in the face of the increasing need for such relief, led to the lawsuit Hansen v. McMahon, which was filed in Los Angeles County Superior Court on April 17, 1986. Hansen was a class action brought by homeless families against the Calfornia Department of Social Services, seeking enforcement of certain provisions in California's Child Welfare Services Act which require the state, through the counties, to provide emergency shelter to homeless families.[1] Due to an overly restrictive interpretation of this statute, the state and counties were only providing emergency shelter to children removed from their families, but not to children remaining with their families.

The Superior Court granted plaintiffs' request for a preliminary injunction in May, 1986, finding that the state's overly restrictive regulations were invalid. The Court issued an order which stated that the state could not refuse to provide emergency shelter to children who remained with their families. The state appealed the injunction and resisted implementing it. The injunction was eventually upheld on appeal. 193 Cal. App. 3d 283 (1987); 193 Cal. App. 3d 1561a (1987) (mod.). Although the state finally informed the counties that they should follow the order, the state never issued specific instructions as to how to implement it and never gave the counties any funds to pay for emergency shelter. So, despite the injunction, homeless families still had nowhere to turn for emergency shelter assistance.

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[1] The plaintiffs in Hansen were represented by the Legal Aid Foundation of Los Angeles, the Western Center on Law and Poverty, and eight other California Legal Services programs.

AB 1733: AFDC Special Needs for Emergency Shelter and Transition to Permanent Housing

Faced with pressure from the Hansen injunction, as well as a growing awareness of the homeless family problem in general, the California legislature passed AB 1733 (sponsored by Assemblyman Phil Isenberg of Sacramento) in September, 1987. This bill amended California's AFDC Special Needs provisions to create a system whereby homeless families could get immediate funds for emergency shelter and also could get funds to pay security deposits and utility deposits so that they could transition into permanent housing.[2] The bill was signed by Governor Deukmejian on September 29, 1987. The new provisions were scheduled to go into effect on February 1, 1988.

There was one hitch, and this should be of special interest to the Committee. Since the new benefits were being provided as a Special Need under the AFDC program, half of the funding would be federal. In order to secure the funding from the federal government, California would have to amend its State Plan for its AFDC program and obtain approval for the amendment from the U.S. Department of Health and Human Services. If HHS did not approve the amendment, then the new benefits would not go into effect.

California submitted its proposed plan amendment to HHS on October 20, 1987. On January 6, 1988, just 3 1/2 weeks before the new provisions were to become operative, HHS notified California that it was denying the plan amendment. The reason given for the denial was preposterous: it would be "inequitable" to give emergency shelter benefits to AFDC recipients who were homeless and not to give them to AFDC recipients who were not homeless. Homeless advocates who were looking forward to the emergency benefits were devastated by HHS's denial of this bi-partisan approach to addressing the homeless family crisis.

Not only was HHS's mean-spirited disapproval of the plan lacking in any substantive basis, but it also appeared to be a direct slap in the face of Congress. On December 14, 1987, HHS had published proposed regulations in the Federal Register which would have restricted the circumstances under which states could provide special needs allowances and emergency assistance. These regulations would have jeopardized approval of California's plan. In response, on December 21, 1987, Congress enacted Section 9118 of the Omnibus Budget Reconciliation Act of 1987, prohibiting HHS from implementing those proposed regulations and from otherwise reversing its current policies for reimbursing states for the costs of serving the homeless through the AFDC program.

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[2] Although not a direct settlement of the Hansen lawsuit, AB 1733 did amend portions of the Child Welfare Services Act so as to remove the legal basis for the Hansen injunction. It substituted the AFDC homeless assistance in its place. The effect was to end the Hansen litigation by creating these new benefits for homeless families.

Although a lawsuit to challenge HHS's ill-advised denial was in preparation, it was fortunately not necessary to resort to litigation. Presumably reacting to concern expressed by some members of Congress who learned what was happening, HHS reversed its position just 3 days before the February 1, 1988 start-up date.

The Provisions of AB 1733: The New State Homeless Assistance Program

The new state homeless assistance program creates a new "non-recurring special need" under the AFDC program. To be eligible, a family must be homeless and approved for AFDC or "apparently eligible" for AFDC. It must also have less than $100 in non-exempt liquid resources. Homeless families are eligible for two kinds of special assistance: temporary and permanent.

WHO IS ELIGIBLE?

A family is considered homeless if it lacks a fixed residence, if it is living in a homeless shelter, or is "living in a public or private place not designed for, or ordinarily used as, regular sleeping accommodation for human beings." A family that is sharing housing is considered homeless if "the housing is being shared on an emergency basis and is temporary." A family may only qualify once every 12 months.

WHAT IS TEMPORARY ASSISTANCE?

Temporary shelter must be provided the same day that it is requested (or the following working day if the welfare department arranges for shelter in the meantime). It consists of $30 per day for a family of 4 or less (plus $7.50 per day per person for a larger family - up to $60 per day).

The $30 may be provided on a daily or weekly basis, and may, at the recipient's option, be provided as a vendor payment directly to a landlord or shelter. The money may be used for temporary shelter such as a hotel room; if there is some left over, the family may use it for its other emergency needs, such as transportation for searching for permanent housing. There is a concern that $30/day may not be enough in some areas to pay for a hotel room.

Temporary shelter assistance can be provided for up to 3 weeks, and extended another week if the family has made a good faith effort but has been unable to locate permanent housing.

WHAT VERIFICATION IS REQUIRED TO ESTABLISH AFDC ELIGIBILITY?

A family which is already receiving AFDC need not be concerned about establishing eligibility, but a family which is a new applicant must establish "apparent eligibility" in order to receive temporary shelter assistance. The county may make no unreasonable demands on the family to provide proof of apparent eligibility. For the most part, documentation is not required immediately, so that the family will get the emergency shelter assistance on the same day it requests it. The only hard and fast rules are:

1) That a non-citizen must provide proof of eligible alien status (citizens need only declare their citizenship); and

2) That a pregnant woman with no eligible children must provide a doctor's statement verifying her pregnancy including the expected birthday of the child.

HOW DOES THE NEW PROGRAM PAY MOVE-IN COSTS FOR PERMANENT HOUSING?

The second kind of special assistance available for homeless families is for permanent housing. The special needs payment will cover most of the move-in costs, including security and utility deposits. It is available for up to 2 months rent for security deposits and/or last month's rent, and up to the actual amount of deposits for utility hook-ups. The family must pay the first month's rent out of their AFDC check. The permanent housing assistance will not be paid unless the family locates housing which has a monthly rent less than 80% of the family's AFDC grant. If the AFDC family will share housing with others, then its share of the rent must be less than 80% of the grant.

Current AFDC recipients who are homeless must be given permanent housing assistance within one day of showing that they have found a place that costs less than 80% of their welfare grant. Families which have not yet been approved for AFDC must be approved and given permanent housing assistance within one day after:

1) they bring in the documents necessary to prove that they are eligible; and

2) they provide proof that they have found a residence.

How the New Homeless Assistance Program is Working

The new special needs provisions have only been in effect for two months now, so it is not possible to give a definitive opinion on their overall success. Nonetheless, it is clear that the availability of these funds is a great leap forward towards dealing with the homeless family crisis. As families learn about the availability of the special needs money, and as welfare department workers learn how to process the funds, it is encouraging to see families who start out homeless and two weeks later are settled in an apartment.

Just earlier this week, when I was on emergency intake duty in my office, I spoke with 3 families who benefitted from the new provisions. Ms. D. and her 2 children had received $210 in emergency housing assistance last Friday, had stayed in a hotel over the weekend, and had already located an apartment for $500 per month. They needed $650 to move in and, within one day, the welfare office arranged this for them. Without this assistance, they would have used their AFDC check for the hotel and would never have been able to pay the move-in costs for an apartment. Ms. P. has 5 children, so she needed a large place. She had arrived from Louisiana about 2 months ago, where she was receiving less than $300 per month for her family. After using the emergency housing funds for several weeks, she located a place to live and received about $1000 for the security deposit. I assisted her in arranging for another $55 to pay for a deposit for electricity. She, too, without this assistance would never have found an adequate place to live. Finally, Ms. S. was just newly homeless with her 3 children. She called our office for assistance, and what a relief it was to be able to send her over to the welfare office with the knowledge that she would be able to receive money for a hotel immediately.

There will undoubtedly be some hitches in implementation, but these should shake out during the next few months. Hopefully, the Legislature and/or the Department of Social Services will be responsive in adjusting the program if necessary so that it works even better.

The Future of the Homeless Assistance Provisions

Our biggest concern is that HHS will attempt to cut off federal participation in the homeless assistance payments. The amendment to California's plan was approved only through October 1, 1988. THESE BENEFITS COULD BE ELIMINATED LATER THIS YEAR UNLESS CONGRESS ACTS TO ASSURE THAT THEY CONTINUE TO BE AVAILABLE. The special needs homeless assistance could be enacted as a nationwide element of the AFDC program, or Congress could assure that HHS approves state plans which will provide this type of assistance. Regular AFDC payments alone are just not enough to get any family from a state of homelessness into permanent housing. There must be special needs payments for temporary shelter and for move-in costs. Other states should be encouraged to follow California's model and provide this assistance.

Other Suggested Solutions

The homeless assistance payments described here are just one step in what is necessary to deal with the homeless family crisis. Some other suggested items:

1. Broader AFDC Coverage. Special needs paid through the AFDC program will only cover those families who are eligible for AFDC. In many states, two parent families are not eligible. AFDC-U (AFDC-Unemployed Parent Program) should be mandatory in all states.

2. More Immediate AFDC Payments. Federal law should require more immediate AFDC payments, so that homeless families who are just applying for AFDC can receive substantial benefits quickly. Immediate need payments should equal a full month's grant. All grants should be paid from the date of application, rather than from the date when the welfare department finally approves the case. The present AFDC system does not sufficiently provide for emergencies.

3. More Funding for Shelters. More family shelters are necessary for homeless families who are not eligible for AFDC. Also, for many families, a few weeks of emergency shelter will not be enough to become stabilized and find permanent housing. Many families need a longer period in the supportive environment of a well-run shelter which provides counseling and social services in order to set themselves up again in permanent shelter.

4. More Low-Income Housing Programs. Even with move-in costs available, as in California's program, many families will not be able to find housing which they can afford.

Attachment: California Assembly Bill No. 1733 (Statutes of 1987)

Assembly Bill No. 1733

CHAPTER 1333

An act to amend Sections 11450, 11452, and 16501 of, to add Section 15200.15 to, and to repeal Section 11454 of, of the Welfare and Institutions Code, relating to public social services, and making an appropriation therefor.

[Approved by Governor September 29, 1987. Filed with Secretary of State September 29, 1987.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1733, Isenberg. Aid to Families with Dependent Children: eligibility.

Existing law provides for the county-administered Aid to Families with Dependent Children (AFDC) program, under which needy families with dependent children are provided with cash assistance.

Existing law provides that a family receiving aid under the AFDC program shall be eligible to receive an allowance for special nonrecurring needs caused by sudden and unusual circumstances beyond the control of the family, and that a family shall only be eligible for this special needs allowance after the family has used all available liquid resources.

This bill would allow a family to be eligible after it has used all available liquid resources in excess of $100, and would revise the circumstances causing the special needs which make a family eligible for the special needs allowance.

The bill would impose a state-mandated local program by specifying that homeless assistance is available to a family seeking shelter when the family is either eligible or apparently eligible for AFDC, and that a nonrecurring special needs allowance of $30 a day shall be available for up to 3 weeks to qualifying AFDC applicant and recipient families for the costs of temporary shelter, which may be increased for large families, also if authorized by the Budget Act.

The AFDC program is supported in part by county funds, and by increasing the cost of the program by revising eligibility standards and by specifying the $30 per day nonrecurring needs allowance for temporary shelter, this bill would impose a state-mandated local program.

Existing provisions of law contain a continuous appropriation of funds for certain public assistance programs, including an amount sufficient to each county for the support and assistance, as specified, including an allowance for nonrecurring special needs, as specified.

This bill, by revising eligibility standards for nonrecurring special needs, revise the continuing appropriation and thereby result in an appropriation.

Existing law also provides for various social services which shall be offered in order to further the welfare of children, including the provision of emergency shelter care.

This bill would specify that, for purposes of the Child Welfare Program, the term "emergency shelter care" means emergency shelter provided to children who have been removed from their parents or guardians.

Under existing provisions of law, AFDC assistance may be paid in-kind or by vendor payments where it is determined there is mismanagement of aid payments in cash by the recipient.

This bill would repeal that provision.

The bill would require the State Department of Social Services to adopt emergency regulations to implement this bill.

This bill would become operative February 1, 1988.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed $500,000 statewide and other procedures for claims whose statewide costs exceed $500,000.

This bill would provide that no reimbursement shall be made from the State Mandates Claims Fund for costs mandated by the state pursuant to this act, but would recognize that local agencies and school districts may pursue any available remedies to seek reimbursement for these costs.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 11450 of the Welfare and Institutions Code is amended to read:

11450. (a) For each needy family which shall include all eligible brothers and sisters of each eligible applicant or recipient child and the parents of the children, but shall not include unborn children, or recipients of aid under Chapter 3 (commencing with Section 12000), qualified for aid under this chapter, there shall be paid, notwithstanding minimum basic standards of adequate care established by the department under Section 11452, an amount of aid each month which when added to the family's income, exclusive of any amounts considered exempt as income or (f) paid pursuant to subdivision (e) or Section 11453.1, is equal to the sums specified in the following table, as adjusted for cost-of-living increases pursuant to Section 11453:

Number of eligible needy persons in the same home	Maximum aid

1	$ 258
2	424
3	526
4	625
5	713
6	802
7	880
8	959
9	1,036
10 or more	1,114

If, when and during such times as the United States government increases or decreases its contributions in assistance of needy children in this state above or below the amount paid on July 1, 1972, the amounts specified in the above table shall be increased or decreased by an amount equal to such increase or decrease by the United States government, provided that no such increase or decrease shall be subject to subsequent adjustment pursuant to Section 11453.

(b) When the family does not include a needy child qualified for aid under this chapter, aid shall be paid to a pregnant mother in the amount which would otherwise be paid to one person as specified in subdivision (a) from the date of verification of pregnancy if the mother, and child if born, would have qualified for aid under this chapter.

(c) The amount of seventy dollars ($70) per month shall be paid to pregnant mothers qualified for aid under subdivision (a) or (b) to meet special needs resulting from pregnancy if the mother, and child, if born, would have qualified for aid under this chapter. County welfare departments shall refer all recipients of aid under this subdivision to a local provider of the Women, Infants and Children program. If such payment to pregnant mothers qualified for aid under subdivision (a) is considered income under federal law in the first five months of pregnancy, payments under this subdivision shall not apply to persons eligible under subdivision (a), except for the month in which birth is anticipated and for the three-month period immediately prior to the month in which delivery is anticipated, if the mother, and the child if born, would have qualified for aid under this chapter.

(d) For children receiving AFDC-FC under the provisions of this chapter, there shall be paid, exclusive of any amount considered exempt as income, an amount of aid each month which when added to the child's income is equal to the rate specified in Section 11461, 11462, 11462.1, or 11463. In addition, the child shall be eligible for special needs, as specified in departmental regulations.

(e) In addition to the amounts payable under subdivision (a) and Section 11453.1, a family shall be entitled to receive an allowance for recurring special needs not common to a majority of recipients.

These recurring special needs shall include, but not be limited to, special diets upon the recommendation of a physician for circumstances other than pregnancy, and unusual costs of transportation, laundry, housekeeping service, telephone, and utilities. The recurring special needs allowance for each family per month shall not exceed that amount resulting from multiplying the sum of ten dollars ($10) by the number of recipients in the family who are eligible for assistance.

(f) After a family has used all available liquid resources, both exempt and nonexempt, in excess of one hundred dollars ($100), the family shall also be entitled to receive an allowance for nonrecurring special needs.

(1) An allowance for nonrecurring special needs shall be granted for replacement of clothing and household equipment and for emergency housing needs other than those needs addressed by paragraph (2). These needs shall be caused by sudden and unusual circumstances beyond the control of the needy family. The department shall establish the allowance for each of the nonrecurring special need items. The sum of all nonrecurring special needs provided by this subdivision shall not exceed six hundred dollars ($600) per event.

(2) Homeless assistance is available to a homeless family seeking shelter when the family is eligible for aid under this chapter. Homeless assistance for temporary shelter is also available to homeless families which are apparently eligible for aid under this chapter. Apparent eligibility exists when evidence presented by the applicant or which is otherwise available to the county welfare department and the information provided on the application documents indicate that there would be eligibility for aid under this chapter if the evidence and information were verified. However, an alien applicant who does not provide verification of his or her eligible alien status, or a woman with no eligible children who does not provide medical verification of pregnancy is not apparently eligible for purposes of this section.

A family is considered homeless, for the purpose of this section, when the family lacks a fixed and regular nighttime residence; or the family has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations; or the family is residing in a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

(A) A nonrecurring special need of thirty dollars ($30) a day shall be available for up to three weeks to families for the costs of temporary shelter. County welfare departments may increase the daily amount available for temporary shelter to large families as necessary to secure the additional bed space needed by the family. This special need shall be granted or denied immediately upon the family's application for homeless assistance. The three-week limit shall be extended one week based upon good cause or other circumstances defined by the department. Good cause shall include, but is not limited to, situations in which the county welfare department has determined that the family, to the extent it is capable, has made a good faith but unsuccessful effort to secure permanent housing within the three week limit.

(B) A nonrecurring special need for permanent housing assistance is available to pay for last month's rent and security deposits when these payments are reasonable conditions of securing a residence.

The last month's rent portion of the payment (1) shall not exceed 80 percent of the family's maximum aid payment without special needs for a family of that size and (2) shall only be made to families that have found permanent housing costing no more than 80 percent of the family's maximum aid payment without special needs for a family of that size, in accordance with the maximum aid schedule specified in subdivision (a).

However, if the county welfare department determines that a family intends to reside with individuals who will be sharing housing costs, the county welfare department shall, in appropriate circumstances, set aside the condition specified in clause (2) of the preceding paragraph.

(C) The nonrecurring special need for permanent housing assistance is also available to cover the standard costs of deposits for utilities which are necessary for the health and safety of the family.

(D) A payment for or denial of permanent housing assistance shall be issued no later than one working day from the time that a family presents evidence of the availability of permanent housing. If an applicant family provides evidence of the availability of permanent housing before the county welfare department has established eligibility for aid under this chapter the county welfare department shall complete the eligibility determination so that the denial of or payment for permanent housing assistance is issued within one working day from the submission of evidence of the availability of permanent housing, unless the family has failed to provide all of the verification necessary to establish eligibility for aid under this chapter.

(E) Eligibility for the temporary shelter assistance and the permanent housing assistance pursuant to paragraph (2) is limited to once every 12 months.

(F) The county welfare departments, and all other entities participating in the costs of the AFDC program, have the right in their share to any refunds resulting from payment of the permanent housing. However, if an emergency requires the family to move within the 12-month period specified in subparagraph (E), the family shall be allowed to use any refunds received from its deposits to meet the costs of moving to another residence.

(G) Payments to providers for temporary shelter and permanent housing and utilities shall be made on behalf of families requesting these payments.

(H) The daily amount for the temporary shelter special need for homeless assistance may be increased if authorized by the current year's Budget Act by specifying a different daily allowance and appropriating the funds therefor.

(g) The department shall establish rules and regulations assuring the uniform application statewide of the provisions of this subdivision.

(h) The department shall notify all applicants and recipients of aid through the standardized application form that these benefits are available and shall provide an opportunity for recipients to apply for the funds quickly and efficiently.

(i) Except for the purposes of Section 15200, the amounts payable to recipients pursuant to Section 11453.1 shall not constitute part of the payment schedule set forth in subdivision (a) of this section.

The amounts payable to recipients pursuant to Section 11453.1 shall not constitute income to recipients of aid under this section.

SEC. 2. Section 11452 of the Welfare and Institutions Code is amended to read:

11452. (a) Minimum basic standards of adequate care shall be distributed to the counties and shall be binding upon them. The standards are determined on the basis of the schedule set forth in this section, as adjusted for cost-of-living increases or decreases pursuant to Section 11453, which schedule is designed to insure:

(1) Safe, healthful housing.

(2) Minimum clothing for health and decency.

(3) Low-cost adequate food budget meeting recommended dietary allowances of the National Research Council.

(4) Utilities.

(5) Other items including household operation, education and incidentals, recreation, personal needs, and insurance.

(6) Allowance for essential medical, dental, or other remedial care to the extent not otherwise provided at public expense.

The schedule of minimum basic standards of adequate care is as follows:

Number of needy persons in the same family	Minimum basic standards of adequate care
1	$ 258
2	424
3	526
4	625
5	713
6	802
7	880
8	959

9	1,040
10	1,130

plus nine dollars ($9) for each additional needy person.

(b) The minimum basic standard of adequate care shall also include the amount or amounts resulting from an allowance for recurring special needs, as specified in subdivision (e) Section 11450, and the amount or amounts resulting from the granting of a nonrecurring special need, equal to the amounts specified in paragraphs (1) and (2) of subdivision (f) of Section 11450.

(c) The department shall establish rules and regulations assuring the uniform application statewide of the provisions of this section.

SEC. 3. Section 11454 of the Welfare and Institutions Code is repealed.

SEC. 3.5. Section 15200.15 is added to the Welfare and Institutions Code, to read:

15200.15. For purposes of Section 15200, any reference to paragraphs (1) and (2) of subdivision (e) of Section 11450 shall mean subdivisions (e) and (f) of Section 11450.

SEC. 4. Section 16501 of the Welfare and Institutions Code is amended to read:

16501. As used in this chapter, "child welfare services" means public social services which are directed toward the accomplishment of the following purposes: (a) protecting and promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; (b) preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; (c) preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; (d) restoring to their families children who have been removed, by the provision of services to the child and the families; (e) identifying children to be placed in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and (f) assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption. Child welfare services may include, but are not limited to: case management, counseling, emergency shelter care, emergency in-home caretakers, temporary in-home caretakers, out-of-home respite care, teaching and demonstrating homemakers, parenting training, and transportation.

As used in this chapter "emergency shelter care" means emergency shelter provided to children who have been removed pursuant to Section 300 from their parent or parents or their guardian or guardians.

The county shall provide child welfare services as needed pursuant to an approved service plan and in accordance with regulations promulgated by the department. Counties may contract for child welfare services, as defined in Sections 16504.1, 16506.1, 16507.1, and 16508.1. Each county shall use available private child welfare resources prior to developing new county-operated resources when the private child welfare resources are of at least equal quality and lesser or equal cost as compared with county-operated resources. Counties shall not contract for needs assessment, client eligibility determination, or any other activity as specified by regulations of the State Department of Social Services.

Nothing in this chapter shall be construed to affect duties which are delegated to probation officers pursuant to Sections 601 and 654 of the Welfare and Institutions Code.

Any county may utilize volunteer individuals to supplement professional child welfare services in the areas of transportation, respite care, and emergency foster care. provided all volunteers agree to be subject to the State Department of Social Services regulations.

SEC. 5. The Legislature finds and declares all of the following:

(a) The Legislature hereby recognizes and acknowledges that child welfare services authorized pursuant to Section 16500 et seq., of the Welfare and Institutions Code are intended to make it possible for children who are victims of child abuse, neglect, or exploitation to remain with their families whenever possible. Further, child welfare services emergency shelter care is to be available only for the purpose of providing shelter for children following removal from their families when these measures are necessary to protect the child from abuse, neglect, or exploitation within the family environment.

(b) Subdivision (b) of Section 300 of the Welfare and Institutions Code underscores the inappropriateness of public intervention in the relationship between parents and their children solely on the basis of unavailability of emergency shelter for the family. The problems of homeless families are best resolved by expanding aid available pursuant to Section 11000 et seq., of the Welfare and Institutions Code so that these families will have access to resources necessary to acquire shelter.

(c) It is the intent of the Legislature to resolve the dispute in the case of Hansen v. McMahon (Superior Court of Los Angeles, No. CA 000974), and Hansen v. Department of Social Services (193 Cal App. 3d 283) and to clarify that the provision of emergency shelter care under Chapter 5 (commencing with Section 16500) of Part 4 of Division 9 of the Welfare and Institutions Code is for children only and not for their parents, guardians, caretakers, or others.

SEC. 6. No reimbursement shall be made from the State Mandates Claims Fund pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code for costs mandated by the state pursuant to this act. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Part 7 (commencing with Section 17300) and any other provisions of law.

SEC. 7. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Social Services shall adopt emergency regulations to implement the system provided for in subdivision (f) of Section 11450 of the Welfare and Institutions Code. The emergency regulations shall remain in effect for no more than 120 days, unless the department complies with all the provisions of Chapter 3.5 (commencing with Section 11340) as required by subdivision (e) of Section 11346.1 of the Government Code.

SEC. 8. The nonrecurring special need for homeless assistance, provided in Section 1 of this act, shall be available to applicant and recipient families, only to the extent that there is federal financial participation available for this assistance.

If federal financial participation is available for applicant and recipient families under Section 1 of this act, then families who fail to meet federal eligibility rules solely due to the requirements of 42 U.S.C. 607 (b) (1) (B) or (c) (i), and as those sections may hereafter be amended, shall also be eligible for aid under Section 1 if the family is eligible for aid pursuant to subdivision (b) of Section 11201, Section 18315, and subdivision (b) of Section 11450 of the Welfare and Institutions Code.

Implementation of Section 1 of this act is contingent upon the availability of federal financial participation for homeless assistance payments to federally eligible AFDC applicants and recipients. If the State Director of Social Services determines that the federal government has failed to approve the payments, Sections 3.5, 4, and 5 of this act shall become inoperative.

SEC. 9. Section 1 to 7, inclusive, of this act shall become operative on February 1, 1988.

O

Chairman **Miller**. Thank you. Patricia.

Ms. **Nagler**. Thank you. What I was going to describe was what happens when preventive services are not provided to a family that is in the system.

In a case I am handling right now, a toddler who had been abused by an unknown perpetrator was allowed to remain in his mother's custody. His social worker, as is typical among social workers in LA County, had close to 70 children in her caseload. Even the most diligent social worker cannot provide necessary services for that many families and in fact, this family in particular, received no services. There were also two other children in the home.

Despite a State regulation which requires social workers to visit children and parents monthly, the child had not been visited for over four months when the Court terminated jurisdiction over the case. A month later, the woman's three children were all removed from her home after a neighbor heard the two year old child being physically abused by the woman's boyfriend. Another older child also showed signs of past abuse. Had the Children's Services worker had the time to visit and, had she had the services available to provide to this family, perhaps this family would still be intact now instead of struggling through the reunification system. The mother is now in jeopardy of losing her subsidized housing because she does not have her children with her. We have to try to move very quickly to reunify this family and to get services to them. I am not sure if that will be able to be done in this case and whether—it will take years before this family will be intact again.

The effect of the lack of services for emotionally disturbed children is particularly severe. In one case handled by a colleague of mine, a court ordered psychiatric evaluation recommended weekly psychiatric visits for a boy who had witnessed his infant sister being severely beaten by his mother's boyfriend. His sister suffered loss of sight, vision and possible brain damage. The boy felt guilty because he could not stop the abuser and began acting out at school by trying to choke other children. The court ordered psychiatrist said that the child should have weekly visits with a psychiatrist. The County said they could only afford one visit a month. In this case, that boy was very lucky because his grandparents were able to pay for the additional three visits. That is not the case for most of our clients.

Even the most basic services are denied to parents such as transportation for a parent to visit a child. Judge Shabo referred to that in his testimony. In one case that I know of, a parent was criticized and reported to the court for not visiting one of her two children. What the report did not say was that the child was placed in an outlying area of Los Angeles County, far from where the mother lived and the mother had no means of transportation or money to go to visit the child. In another case where the Court ordered the Department to provide transportation for visitation, the CSW responded that transportation would be provided if funds were available. Obviously, there were no funds available for visitation and therefore, it was not going to take place in that case; it was an empty order. Visits between the parent and the child are so fundamental if reunification is to take place. They are so inexpensive to facilitate, it is hard to imagine that that is a problem.

When Mr. Chaffee was testifying, he talked about the problem of placing severely emotionally disturbed children in foster care. While I was talking in the back of the room with a colleague of mine, she told me about one success case which showed that if you had a coordination of services, you could effectively work with a severely emotionally disturbed child and not be forced to put that child in a group home. This was a 12-year-old severely emotionally disturbed child who had failed 25 placements already. She was rejected by 20 other placements. She was appointed a pro bono attorney who pressured the Department of Children's Services to work with the regional center and the Department of Mental Health. Working together they were able to get this child the services that she needed. They found a foster parent who was willing to take the child. The regional center agreed to provide treatment to the child three times a week at home and the Department of Mental Health provided family counseling for the child. The child has now been in that foster care placement for four months. This is the longest placement she has ever had and it looks like it is going to be successful.

It shows that if care, time and coordination of services are provided, the system can work. It is terrible that we do not understand that the key is really preventive services. We all know that and it has been said here over and over. Congressman Miller, I know that you are aware that the provision of services to prevent removal of the children from their family is the key since you were an architect of this very law that we are talking about today. Yet, we do not provide these services. We do not have home based care. We do not go into the home and teach parents proper disciplining methods to use with their children nor, do we provide parents with respite care. We do not do the things that would be inexpensive. Instead, we place children and families in the system. That is not a cost effective approach, not just for children, but for society at large.

I thank you for allowing us to testify today because I hope that this hearing will lead to more effective legislation and the provision of money to solve the problems that we are describing.

[Prepared statement of Patricia Nagler follows:]

PREPARED STATEMENT OF PATRICIA L. NAGLER, STAFF ATTORNEY, GOVERNMENT BENEFITS UNIT, LEGAL AID FOUNDATION OF LOS ANGELES, LOS ANGELES, CA

I. INTRODUCTION

Thank you for inviting us to address the House Select Committee today. As you may know, the Legal Aid Foundation of Los Angeles provides free legal services in civil matters primarily in the area of housing, government benefits, employment, education, immigration, consumer matters, family law, and law enforcement. There are an estimated one million people in Los Angeles who are eligible for our services. We have become involved in the issues affecting abused and neglected children as a result of seeing increasing numbers of clients who are not receiving the government benefits and services to which they are entitled under federal and state law and regulations in the foster care and dependency systems.

The Foundation recently created a Children's Rights Task Force to bring together legal workers within the Foundation who are representing clients in matters regarding children's rights to provide greater coordination of our efforts. We include representatives of other legal aid programs in Los Angeles County in the task force. The major focus of our efforts has been in the area of government benefits programs affecting children (AFDC, AFDC-foster care benefits and health care access including Medi-Cal), services for homeless children and families, and services to abused and neglected children. We have testified before the Los Angeles County Commission on Children's Services, met with representatives of the County Department of Children's Services, foster parents, and others who are concerned with issues affecting abused and neglected children.

We are very appreciative of the work that this Committee has done to resolve many of the serious problems facing abused and neglected children in Los Angeles and throughout the Country. Congressman Miller has been a leader in advocating for abused and neglected children, including being one of the architects of Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980. Congresswoman Schroeder has recently visited many cities in the United States, including Los Angeles, to bring the problems facing poor children and families to the attention of the public. We know that your committee has held many hearings over the years on issues such as preventative services to abused and neglected children, homeless children, and other matters.

We hope that the hearing today will allow your committee to develop creative proposals to solve the dilemma that abused and neglected children and their families face: despite the excellent provisions of Pub. L. 96-272, it's not working--partly because the preventative and reunification services have never been adequately funded by the federal, state or local governments, and partly because the provisions have not been enforced by the agencies of those governments charged with making preventative and reunification and reasonable efforts more than mere rhetoric.

Nationwide, there have been some gains made in terms of reducing the amount of time children spend in foster care and in recognition that foster care is not the only option for families in crisis--that preventative and home-based services should be provided as a first resort--to prevent the devastating and expensive option of foster care placement.

In Los Angeles County, however, our system for providing preventative and reunification services and our court system are overburdened by huge caseloads. Thirty percent of all referrals for child protective services in California were made in Los Angeles County. Yet, as of April 1, 1988, Los Angeles had not complied with Welfare and Institutions Code Section 16501 which requires the County to submit to the State Department of Social Services for approval, a plan or description of the child welfare services which they offer.

At a recent conference on Reasonable Efforts organized by the Permanent Families Project of the Dependency Court, Presiding Judge Dorothy Doi Todd reported that there were over 29,000 children under Dependency Court jurisdiction, with 20,000 of those in foster care. There are approximately 1,700 original petitions filed monthly. Annually, roughly 39,000 judicial review hearings are also held. There are only 15 courtrooms available. Simple mathematics tells us that the judicial officers are unable to give each case the detailed attention it deserves because of the volume of cases.

Currently, social workers have caseloads which often range as high as 60 to 70 cases. There have even been reports of workers with caseloads of 120. Common sense tells us that the social workers cannot properly provide preventative and reunification services with caseloads of that size. It is mathematically impossible for them to even visit the children in their caseloads as frequently as required by state regulations, let alone as frequently as is necessary to provide the proper social work services needed by these children in order to allow them to remain with or be reunited with their families. Nor, can they effectively provide services to the parents and siblings of these children. In fact, as was reported in local newspapers, children's services social workers recently threatened to stop accepting any additional cases for fear that they could not properly provide the necessary services. In response to this information, the County Board of Supervisors acted to appropriate emergency funds, but those funds alone cannot resolve this severe problem. Even with this emergency appropriation, the agency still will be without enough social workers to meet the need.

At the recent conference on Reasonable Efforts, social work officials from Solano and Stanislaus counties talked about their innovative efforts to provide home-based preventative and reunification services. In Solano County social service support workers are used to provide services such as parenting skills training, transportation, and homemaker services so that families can be kept together.

In Alameda County, officials have recognized that a social worker must work intensively with a family in order to provide the services necessary to reunify the family. Therefore, Alameda County had reduced caseload sizes for Family Reunification workers from 39 to 23 children. This stands in stark contrast to the situation which exists in Los Angeles County.

There are a number of groups composed of social services professionals and private citizens who are concerned about the crisis in the foster care/dependency systems. We work closely with the Los Angeles Commission on Children's Services which is the oversight agency for all county programs serving abused and neglected children. The United Way recently issued a report on the inadequacy of health services to foster children and has a task force looking into this and other problems affecting abused and neglected children.

We are aware of the efforts of the dedicated staff and volunteers at the Child Advocates Office, which is part of the Dependency Court, to provide abused and neglected children with guardians ad litem so that their voices will be heard by the Court and they will receive the preventative and reunification services they need.

We know that members of the Board of Supervisors, particularly Supervisor Edelman as well as Supervisors Hahn and Dana have been concerned and taken steps to support the provision of appropriate services to abused and neglected children.

We have been meeting with representatives of the Department of Children's Services for more than a year to seek solutions to these problems with no success. We have no doubt the Department is staffed with social work professionals who are dedicated and committed to abused and neglected children, particularly at the field level, where they face incredibly difficult decisions with inadequate resources.

Given this background, however, we must conclude that the system isn't doing what Congress intended. We will address this briefly in our oral testimony today, and provide these more extensive written comments for your review. We ask your Committee to help us make the system work--through better funding, better enforcement, and exercising leadership in proposing innovative solutions.

II. SUMMARY OF TESTIMONY

I will be addressing the problems of failure to provide proper government benefits and services to abused and neglected children and those placed in foster care.

The areas I will address in my presentation are :

1. The failure of The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) to assure that preventative and reunification services are available in sufficient quantity and quality to achieve its purpose: a)the prevention of unnecessary removal of children who are abused and neglected from their homes; b) if removal is necessary, to assure that services and benefits are available to reunify the family and to provide children with the resources and services necessary to ensure their proper care and development; and c) if reunification is not possible, to assure that each child achieves a permanent home.

2. The inadequacy of current health care services available to children.

3. The problems of immigrant children who are abused and neglected and the special problems they face while under state custody.

III. LACK OF PREVENTATIVE AND REUNIFICATION SERVICES TO ABUSED AND NEGLECTED CHILDREN

When Congress passed the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272), it required states to engage in reasonable efforts to prevent unnecessary foster care

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placement, to provide reunification services to assure the prompt reunification of families where possible, and if reunification is not possible, to assure that each child receives a permanent home.

Unfortunately, Pub. L. 96-272 has not been adequately enforced or funded. In Los Angeles County, there are approximately 29,000 children under dependency court jurisdiction. Of these children, approximately 70% are in foster care. There were over 17,000 dependency petitions (new and supplemental) filed in 1986-87. The Court conducted almost 39,000 review hearings (including permanency planning hearings).

As previously mentioned, caseloads of children's services workers have reached crisis proportions. As a result of a yardstick study performed by the state, they recommend that a family maintenance/family reunification social worker's caseload be 35 children. In Los Angeles, children's services workers often have caseloads of 60-70. We are told that adoptions workers have caseloads in the 100's, up to 150 children. It is not mathematically possible to even visit the children, parents or foster parents as required by state regulations, must less provide preventative or reunification services. State of California, Manual of Policies and Procedures (MPP), Chapter 30 et.seq.

Social Workers complain that there are not sufficient bilingual children's services workers to meet the needs of the large number of the children who speak only spanish. Also in many cases, the children may speak english, while the parents speak spanish or another language. A children's services worker who speaks only english cannot provide preventative or reunification services if he or she cannot communicate with the child or family. At a recent hearing held by a subcommittee of the Children's Services Commission, a social worker described how a mother, who spoke only spanish, had her child removed from her care by a social worker who spoke only english. Because the child's mother was not able to understand the social worker's instructions about the court hearing she did not show up. The problem was not resolved until a bilingual worker was finally assigned to the case. Moreover, the first social worker was not able to determine if there were any alternative placements available for the child, such as with a relative.

I will summarize some of the problems here:

A. FAILURE TO PROVIDE PROPER NOTICE OF ELIGIBILITY FOR FOSTER CARE BENEFITS AND OTHER SPECIAL NEEDS PAYMENTS, IMPROPER DENIAL OF BENEFITS, AND EXTREME DELAY IN PROCESSING APPLICATIONS AND MAKING PAYMENTS EVEN AFTER HEARING DECISIONS AWARDING BENEFITS.

In Los Angeles County, there has been a serious problem with delay in processing applications for federal and state only foster care benefits, particularly Youakim v. Miller, 440 U.S.125 (1979) payments to relatives. Both related and unrelated foster parents must wait for months, and in some cases, over a year, to receive benefits to which they are entitled in order to pay for the care of the children placed with them by the dependency court. In some cases, bureaucratic hurdles create a Catch 22 situation--the foster parent/relative must locate a missing parent in order to obtain information about the child's prior eligibility for AFDC benefits--yet the reason the child was placed in foster care with the relative is because the parent is missing or unable to provide proper care due to drug abuse, mental illness or other problems. I have seen these problems in case after case. One such case graphically illustrates the problem because this client experienced delays at every juncture of the system. Unfortunately, what happened to this client appears to be the rule and not the exception.

I was assisting a grandmother obtain federal Youakim benefits for her two grandchildren who had been deserted by their mother (her daughter), a drug addict. For the first six month she cared for her grandchildren, she was not even told about the possibility of getting foster care benefits for the children. Instead she was made their payee for federal AFDC-FG benefits, since she herself worked. When she was finally informed that the children were potentially eligible for benefits, it then took 10 months for the children's application to finally be approved.

During the course of the application process, the children were erroneously denied benefits twice. The last time because my client could not locate her daughter in order to show that she had been eligible for AFDC-FG in the month the judicial dependency petition was filed. The County had imposed this requirement on the grandmother despite the fact that it is the County, not the foster parent, who has the duty to obtain the necessary evidence to process the children's foster care applications. Even after the State ordered the County to obtain this information, it was my client not the County who ultimately tracked down her daughter. Then, after the application was approved, it took months before the checks started to arrive on time. Their July checks were 29 days late.

It is also not uncommon for the children's services worker to verbally tell a related foster parent that they are not eligible for federal foster care benefits. Since they do not receive written notice of denial, they are unaware of their right to appeal the decision.

There is also a widespread failure to train children's services workers about the variety of special needs payments which could be used to prevent removal or to assist in reunification, such as AFDC advance payments to allow a parent to secure housing and furniture in anticipation of the child's return home. Too many times I have spoken to mothers who tell me the Court and their social worker have told them their children will be returned to them if they can get a place to live. In one such case, the woman had successfully completed a drug program and parenting classes but could not afford an apartment on her meager general relief check. Her social worker had not told her she could get an advance payment of AFDC or that she could receive a special needs payment to secure housing and necessary furniture. It took me hours of phone calls to the Department of Children's Services and the Department of Public Social Services to facilitate this for her.

B. FAILURE TO PROVIDE APPROPRIATE PREVENTATIVE AND REUNIFICATION SERVICES TO CHILDREN AND FAMILIES TO PREVENT UNNECESSARY FOSTER CARE PLACEMENT AND TO REUNIFY FAMILIES.

Although the judges in the Dependency Court are required to make a written finding that reasonable efforts have been undertaken prior to removal of a child from the family, the only source of information about whether reasonable efforts have been made is the Department of Children's Services. The judges have no independent way of determining what services should be provided and whether they have, in fact, been provided. Since neither Pub. L. 96-272 nor federal regulations specify what services should be provided, there is an absence of federal standards. As a result, the judges may simply check the box on a form judgment that reasonable efforts have been provided, even when there is no evidence whatsoever showing what efforts have been provided.

Los Angeles County is fortunate to have a model program for providing volunteer Guardians Ad Litem and court assistants through the Child Advocate's Office which is a part of the Dependency Court. However, Guardians Ad Litem are appointed in only a small number of cases, and thus, the children are deprived of the benefit of an independent advocate on their behalf who can advise the court about services that should be provided. Many states lack guardian ad litem programs and instead consider the social work representatives of the state agency as the guardians for the child. Since these social workers are overburdened with high caseloads and must adhere to agency policies which reflect institutional concerns, there is frequently a conflict between a truly independent assessment of the best interests of the child and the agency's recommendation.

Observations of cases in the overburdened dependency court in Los Angeles show continued unnecessary removal, failure to provide basic transportation to visitation and other services for parents, failure to provide necessary psychiatric and other mental health services to children and parents, failure to provide child care services, failure to follow visitation frequency regulations, failure to provide necessary health services, and grossly inadequate recordkeeping with respect to children in foster care.

For example, in most cases, social workers are required by state regulation to visit the children on a monthly basis. MPP Chapter 30 et. seq. However, it is not uncommon for a social worker to go for months without visiting these children or to count as a visit, seeing the children in court. In one case a two year old child who had been physically abused by an unknown perpetrator was allowed to remain with his parent. Neither the parent or the child were provided with any services. The social worker had not seen the child or the family for four months when the court terminated jurisdiction over the case. A month later, the woman's children were all removed from the home after a neighbor reported that the two year old was being physically abused. Another of the woman's children also showed signs of physical abuse.

In another case I am aware of, a woman's two children were placed in completely different parts of Los Angeles County. The mother did not have a car and she was not provided with money or a means of transportation in order to visit one of the children who was placed very far from the mother's home. Even though the social worker was aware of why the mother could not visit the child, the mother was criticized for this in the report to the court. Social workers have also been heard to tell the court that funds for visitation will be provided to the parent only if the money is available from the department. Yet, visitation between the child and the parent is critical to the process of reunifying the family.

The problems of foster care are particularly severe for emotionally disturbed children. In one of my cases, four children were placed with a relative after being abused. The two older children had been sexually abused. The two younger children, a toddler and a six year old were acting out. All four children required intensive psychiatric care. The children had a social worker assigned to their case. None the less, it took my client (who at the time was unrepresented) almost a year to force the County to help her get psychiatric care for the children.

In another case, a court ordered psychiatric evaluation recommended weekly therapy sessions for an eight year old boy who had witnessed his infant sister being severely beaten by his mother's boyfriend. His sister suffered loss of sight, vision, and possible brain damage. The boy felt guilty because he had not been able to stop the abuser. He began acting aggressively at school, trying to choke other children. His social worker told his grandparents, who were awarded temporary custody of him, that the Department of Children's Services could only afford one psychiatric visit per month. Thus, the grandparents were forced to pay for the three other monthly visits.

Handicapped children face special problems. We are informed that children in wheelchairs in Los Angeles County are deprived of their right to appear before the judges in dependency court because there are inadequate transportation services for such children. Deaf children are not provided with adequate services. The whole issue of what happens to children who are in so-called temporary shelters but who stay for long periods of time due to difficulty in finding placements needs to be explored.

A report prepared by Dr. Vivian Weinstein for the Department of Children's Services in 1986 describes the types of home-based preventative and reunification services that should be provided in Los Angeles County but are not available at all or are available on a limited basis, such as homemaker services. The Weinstein report discusses the history of services to abused and neglected children in California, which had served as a model to the nation, and the devastating effect of federal, state, and local funding cutbacks which shifted funding away from the preventative services that had made the state a model.

IV. LACK OF HEALTH CARE FOR FOSTER CHILDREN

Research discussed in a recent United Way report on the lack of proper health care for foster children shows that foster children have significantly more health problems than other children of similar ages. They have lower growth levels, greater frequency of chronic medical conditions, and increased frequency of dental problems. Often medical and immunization records are sketchy or non-existent for children who enter foster care. Foster children, as victims of abuse and neglect, suffer mental health problems as a result of the abuse/neglect, as well as difficulties related to the removal from the family and uncertainty of placement. There is a shortage of physicians and dentists willing to treat foster children. This is because there is a general shortage of physicians and dentists who accept Medi-cal (Medicaid) because of the low reimbursement rates, delays in payments and excessive paperwork required. Also, many physicians are reluctant to treat foster children because there is inadequate record keeping of the child's health history both prior to removal from the family and while the child is in foster care. On top of this, foster parents often experience problems in obtaining medi-cal cards for their foster children.

The lack of mental health services for emotionally disturbed children is a severe problem in Los Angeles County and results in seriously emotionally disturbed children remaining for long periods of time in institutions for temporary placement because they cannot be placed in the limited number of foster homes who can accept such children. Adequate mental health services are not available in temporary shelters and there have been allegations that children in need of mental health services are over-medicated rather than being provided with necessary mental health services.

V. LACK OF SERVICES FOR IMMIGRANT CHILDREN WHO ARE ABUSED AND NEGLECTED

Abused and neglected children who are immigrants face very special problems when they are placed in foster care. The extent of this problem is not known, but in an area like Los Angeles where there is a huge immigrant population, it is estimated that there may be hundreds of immigrant children who are in the care, custody and control of the State. Many of these children reach the age of 18 while still in foster care without any provision made to resolve their immigration status. Very little is being done to determine how many of these children may be eligible for amnesty under the Immigration Reform and Control Act of 1986, although the Dependency Court in Los Angeles is attempting to address the problem for those children who are identified as immigrant children.

When these children are no longer under the custody and protection of the State because they reach the age of majority, they could face deportation to a country where they have no family and do not speak the language because they were raised in the United States. These children cannot legally work and support themselves, and are at risk of turning to dangerous and illegal ways of surviving. In one case, a ten year old Yugoslavian girl visiting relatives in the United States was sexually molested by her uncle. When her only living relative, a grandmother in Yugoslavia died, the girl was then taken in by people in her Sunday school. She was made a dependent of the court and grew up in the United States. Nothing was ever done about her immigration status. Now at age 18, unable to work or to enter nursing school, she faces possible deportation to Yugoslavia. These children are wards of the Court and the County has the duty to ensure that their needs, including their need for immigration services, are attended to in a timely and appropriate manner.

VI. CONCLUSION

This Committee should be commended for holding this public hearing to gather information about the problems in Los Angeles. Adequate funding is needed to implement current legislation protecting the rights of children and families to economic security and adequate health care. There should be stronger enforcement of the Adoption Assistance and Child Welfare Act of 1980 and sufficient funding to assure that children are safe from abuse and neglect by their parents and other caretakers. In addition, Congress must assure that children who have been removed from their families because of abuse and neglect are safe from abuse and neglect by the very system that has intervened to protect them. There are model programs that exist that have proven that home-based, preventative and reunification services do work and are cost-effective. However, because of federal and state budget cuts and shifting of funds, and the lack of proper priority setting, preventative services are no longer a priority. Once again, an expensive and often inappropriate foster care system is being used as a dumping ground, just as it was before 1980 when Congress passed Pub.L. 96-272. Congress thought it was solving the problem--but it hasn't worked and we need your help to make it work. Congress made a promise to these children and families, and Congress needs to make sure that promise is kept.

Chairman MILLER. Thank you, very much. Mr. Ramos.

STATEMENT OF DANNY RAMOS, MEMBER, LOCAL 535 SEIU; SUPERVISING CHILDREN'S SOCIAL WORKER, DEPARTMENT OF CHILDREN'S SERVICES, LOS ANGELES, CA

Mr. RAMOS. Mr. Chairman. I am not going to scare you into thinking I am going to read my statement. First of all, I was given a time limit and I have taken direct statements from that that I think you just must hear and try to stick to my time limit.

Chairman MILLER. Thank you.

Mr. RAMOS. Please do not deduct this though from my time limit in terms of the concern in relation to the gang connection that you indicated just a little earlier. Allow me to introduce myself first, and I would like to make just one brief comment in regards to that.

My name is Daniel Casillas Ramos. I am a Local 535 member, SEIU, and a Supervising Children's Services Worker for the Department of Children's Services here in LA County. Just in regards to this particular matter I just briefly aforementioned, I was a DPO [Deputy Probation Officer], working in a locked facility for two years between 1975 and 1980, of which the last three years I was a DPO in a treatment center.

You are absolutely right. There is a an absolute direct connection in regards to the fact that there are—a majority or percentage of our children at this time which are prime candidates for these institutions. I supervise children in what we call the "Box." Locked rooms for minors that are under the age of 18. Individually saw welts and scars on their heads from extension cords or physical abuse and heard them tell stories of how they were getting to the big house with their family members like uncles and aunts who are already within the penal institutions. So, you are right on in regards to that assumption and I would like to tell you with my direct experience in this field, I concur with you.

I would like to move on now. I am, myself, have had approximately 25 years in experience with this agency, although I may not look it. I was adopted. My brother was adopted. My adoptive parents were LA County foster parents for almost 18 years. I came on board instead of a recipient of services in 1980 to become a provider of services in 1980 as a Children's Services worker too.

I would like to bring today's attention to three main particular concerns that I will speak to; that is, caseloads, the Dependency Court and paperwork. In addition, there are five more areas of great concern that I do not have time to address that I will speak to. Those are, this job is dangerous. Two, children and their families are traumatized by rotation of many social workers. Those that are leaving the agency due to burnout, those who are leaving the agency or transferring around to other offices and all kinds of other reasons for that. Number three, in the largest Hispanic community probably in this Country, the Hispanic child and family are the least serviced. Number four, there exists no standards of task in this agency. In every office, and I have worked in three at least, we do everything totally different. It is either more paperwork or more paperwork. Five, clerical support is in need of critical support. Since they are all aware that they are all the backbone of any good organization and critical operations.

I would like now to direct my comments to caseloads. They are in the 70's. There are some in the 50's but getting there in the 70's. In the last office I left, before I was promoted two weeks ago, my caseload was 68. I visited that office yesterday. The caseloads in the treatment section which are post-dispo, not prior to disposition, if you understand the language, sir, there are, at this time, 75. In my own unit in south central Los Angeles where is my current assignment, the average caseload in my unit is between 75 and 78 and rapidly climbing.

The demands of caseloads this size are overwhelming, 144 with the work that is required. CSW's fall into two categories; those who can work weekends in the office and/or take cases home. May I reiterate, take cases home, and/or both. Those who cannot, they go out on stress or what is commonly referred to as medical leaves, or find employment elsewhere. After we spend thousands of dollars in training, they are prime candidates for community agencies because of the fact that they are now—they have become familiar and trained with where our system does not work.

Face to face contacts or mandated activities in regards to the monthly visitations are another demand of caseload activity. CSW's do not have time to do the state exemption forms which would require them to do less phone calls. They do not have the time to make all the home calls they are supposed to make. Monthly visitation statistics which come at the end of the month and which our Department relies on, are inaccurate and inflated. Workers are forced to lie, to find the happy medium between mandated activities and the avoidance of administrative pressures. We are Band Aid crusaders running from one fire to another and sometimes we need Band Aids ourselves.

In March, last month, we lost 40 CSW's. Our average attrition rate is 15 or 16.

I would like to move on now to the Dependency Court issues. The Dependency Court requires too many reports than the mandated two Judicial reviews that are required by SB-14. Our court system compounds the traumatization, especially in the bi-lingual family. At this particular time, mostly so in the Hispanic community as they encounter the Court system. I have had court orders that direct me to determine whether or not drugs are being sold within a caretakers home that a Court has ordered children in on the preponderance that a parent makes allegations that drugs are being sold. I am not a policeman. I have not a license to become a detective, a private eye. I am a social worker and unless I stake that house out and I do not carry a gun, how can I make that determination.

Court staffs exist in terms of bi-lingual. We have Spanish speaking court offices, Spanish speaking bailiffs, Spanish speaking judges from time to time. We have Spanish speaking attorneys. Yet, we have no, in the past, nor at this time, nor in the future, to my knowledge, of any type, are we going to implement bi-lingual department courtrooms to lessen the Court and legal traumatization of our community.

Court forms for these people in their languages, whether it is Spanish speaking, Asian, Vietnamese, Cambodian, whatever it is you want to call it, do not and are not existent. And I have brought this matter to the attention of our Department as well as the Court system, yet, our Department and our Court system demands that we notify these people of the appropriate forms of which, if they got these forms anyway which are Certified Mail, they do not even understand what the forms are telling them and that is basically the fact that they have to appear at a certain time and date in relation to what type of hearing.

Due diligence situations are pretty much the same situation. The fact that these court reports are not done in their native languages and these court reports have the vital case plan which supposedly require parents' signatures that they understand what it is that the Court is telling them and these court reports are in English only.

Paperwork, prior to 1986, and I am getting to that at this time, and regards to the fact that workers were emphasizing streamlining of paperwork. We are inundated, overwhelmed and if you just take the time to come to a District Office, you will see what exactly it is that I am talking to you about. I have brought samples of forms of which you are more than welcome to have and/or look at in regards to things which we must file continuously and duplicate in carbons and then file away. When this form gets done, this form must be done in addition. This is a computer form. DCS increases—we have attempted to eliminate and have brought to the attention of our Department the eligibility function in regards to Youakim matters, in regards to other matters of foster care payments. We are not eligibility workers. We are social workers. We are concerned more in relation to the job of people work rather than paperwork.

In closing, as I am sticking to my time limit here——

Chairman MILLER. Thank God. [Laughter.]

Mr. RAMOS. I would simply like to say this, and I will leave you with a quote.

"To achieve all that is possible, we must attempt the impossible. To be all that we can be, we must dream of being more." Mr. Chairman, Congressman Miller, we social workers are constantly attempting to achieve the impossible and we, the social workers of Los Angeles, are consistently, constantly dreaming of being and doing more. Thank you.

[Applause.]

[Prepared statement of Danny Ramos follows:]

PREPARED STATEMENT OF DAN RAMOS, SUPERVISOR OF CHILDREN SOCIAL WORKERS WITH THE DEPARTMENT OF CHILDREN'S SERVICES IN LOS ANGELES COUNTY, LOS ANGELES, CA

Mr. Chairman And Members Of Congress

My name is Dan Ramos, I'm here today as a member of local 535 SEIU and a supervisor of Children SOcial Workers, with the Department Of Children Services here in Los Angeles County.

I've been a part of this agency off and on for the last thirty years. You see for the first five years of my life. I was a client of the Department Of Adoptions. My adoptive parents became Los Angeles County Foster Parents for almost the next fifteen years. Shortly after the second adoption of another child, my younger brother Richard. I remember as for back as court hearings at the time my name was changed to our home in East Los Angeles in the middle of the night for emegency placement.

I came to the other side of the fence of this agency in 1980. My first assignment was to cover what is called an uncovered file. Receiving it had no worker of about fifty-two children in Norwalk. Five years later I went to work in the East Los Angeles office literally blocks from where I grew up. My current assignment is supervising a unit in South Central Los Angeles. My purpose today is to share with you the overwhelming task of protecting and providing services to the abused child and the future of our community.

To begin with we are inundated with paperwork in addition to peoplework.

(30-40 seconds showing of examples)

Members of this committee please bear in mind the cases which aren't screened out by the system of such an intensity of molestation or physical abuse and/or drug abuse that they require full-time supervision and contact sometimes several times a week. It is not unusual for these cases to have all three elements of above mentioned.

1. Caseloads Three weeks ago I left a caseload of sixty-eight children/ bilingual standard number of cases in the East Los Angeles office is between 70-75 caseloads of my unit presently are 52,60,68,75,76,78. Two CSW'S in my unit have four years, four have two years and five with the S.B. 14 mandates it is an impossible task to see all these children including parent or parents. Every month workers don't even have the time to fill out the state exemption forms for visitation in order to lessen the number of required visits, when monthly statistics are due. this area is extremely here because CSW'S are between a rock and a hard place, or should I say mandated activities and the managements pressure to do the impossible. As a result those CSW'S who can work week-ends and take work home cases included those who can't go out on stress commonly reffered to as medical leaves. In the last office than there were approximately six workers out on medicals. Multiply that times seventy children, that's 420 children being carried by other workers.

The accuracy of monthly contacts is also desputable CSW'S hurt our own cause for additional funding as the basis that (not all but a majority) don't give accurate contact numbers they are somewhat inflated because of management pressure to do the job that can't be done but real contact numbers would alarm and alert supervisors to single out individuals not for assistance but for disciplinary measures. As a result we band-aid crusaders find. We not only are band-aiding family crisis situation to the next but also our own bureaucrative systematic deadline demands until as we're always thinking "going to get on top of things."

2. The Dependency court does much to hinder the front line workers by.

A. Requiring much more than two reports a year as mandated. Due to the intensity of abuse in our dysfunctional families CSW'S are ordered to do sometimes three-four sometimes five additional reports before the next judicial review. These range from progress report as to why a child at Mclaren Hall hasn't been placed (every fifteen days) to suplemental reports ordering a worker to determine whether or not there are drugs being sold out of a caretaker's home.

B. Court reports are a high Department priority due to the number of continuancces that are given for such reasons as late notices to parties, to no reports at all due to the high caseload matter.

C. CSW'S are required to give reasons in writing as to why a matter called "court alerts" that if a report isn't done within four-seven days of the court date, the CSW must stopped everything and get that report done before the end of the day. This increases the stress levels of a highly stressful situation.

D. The CSW and our supervisors are subject at a whim to many appearances at court for verbal repremands from judges, commissioners and refferals because of refferals, because of reports not being submitted in a timely manner or as frivolous as clarifying a typo-graphical error. The technicalities of our legal system certainly add to the traumatization of our dependent children and their families. Taking the bilingual issue which is a critical area, for lack of services, in this large hispanic community

There are bilingual courts clerks, court officers, attorneys and judges and yet there hasn't been, isn't now nor to my knowledge plans to be any dependency court department that is bilingual. The court atmosphere including legal language compounds tremendously the effect of traumatization (a systematic are) the child and family experiences. Which in reading cases is devastating and life-impacting for the child and family.

The addition to actual court activities there doesn't exist the paperwork support system such as notice of hearing in other languages nor court reports that contain actual and vital case plans.

This leads me do the next area of grave concern.

3. Paperwork There exists just too much paperwork.

This paperwork were told in mostly mandated by the State Department Of Social Services but the duplication and triplication of information, that must be placed on different forms in addition to updating our computor system that seems to make more errors than we do is the most frustrating aspect of our job. We ask continuously to be relived of eliqilibity/financial functions that literally bog down the front line worker from doing actual casework in the field rather the usual 2-3 days of a week sitting in the office initiating paperwork of all types. As a recent member of a committee to streamline forms the task is as tedious and frustrating as doing the actual paperwork. (Demonstration Of Eligibility Paperwork)

Interjection: A disturbing note about "time study" months.

a. Codes as time elements on cards, (explanation).
b. Felacy about the reflection of work thats done without the documentation of overtime.

Another monster that is dreaded at the line is the "YOUAKIM" case. The paperwork has been relieved at the front line but the systematic problems regarding payment have continued and worsened.

Reasons:

A. The court is placing more and more children with relatives than ever before. Families are mis-informed at court that if they come to the aid of their family, they're entitled to aid from our foster care system. Not always true due to the rigid federal regulations. SHould they not qualify there's always AFDC-FG aid that takes 6-8 weeks. If they do qualify it could take 8-12 weeks and in some instances 4-8 months. All the while the family receives no aid. (cite specific case:)

B. For the undocumented there is no aid and the system traumatizes the child further by placing an undue financial burden on the unsuspecting family. Such situations even require emergency placements later which further traumatize they child.

Other areas of grave concern are (a FRW remarks to mention specific too)

5. Job Hazards.

   a. CSW'S have been shot at.
   b. Threatened by knives.
   c. Damage to personal property in cars(skid row unit)
   d. CSW beaten by client while serving a citation.

6. Case Assignments:

   a. Children having one caseworker after another. (not unusual) beaureacratic trauma. Department Experiment; Exposition Park Office; Vertical case management.

7. CLERICAL SUPPORT:

   Extremely essential, even vital. Severely short-staffed. (As seen by front-line VS. clerical allocation) especially under city offices. Possible inequitable distribution of clerical staff.

8. No standards of tasks Department-Wide. Every office does everything totally different from one another.

9. Bilingual Issues: Specific to hispanic's a mono-lingual workers servicing bilingual.

   FAMILIES

   b. Lack of agencies with qualified bi-lingual staff.
   c. Bi-Lingual CSW'S being supervised by Mono-Lingual supervisors.

10. Closing remarks.

Thank you sincerely,

Daniel Casillas Ramos

Daniel Casillas Ramos, SCSW
Department Of Children Serices
1740 East Gage Avenue
Los Angeles, CA 90001
(213) 586-7185

LOS ANGELES COUNTY LETTERGRAM

TO	Al Garcia, DCSA	FROM	Manny Gomez, SCSW

CASE LOADS AND ALIA

Date 08-13-87

Al, caseloads are reaching a very critical point. We all know that no worker can meet the state mandated requirements to protect children with a caseload of 50 plus children. On tops of that, our workers have to spend many hours correcting CIS, Foster Care Payment problems, and other systems problems over which workers have no control. I have observed that workers may have to spend as much as 60% of their work time attempting to fit various system problems. The court is also becoming more demanding, ordering specific home calls and other activities that require extra time and energy.

Workers feel they are losing control of their workload and find themselves responding to an ever increasing number of emergencies with no time left for developing and planning sound and appropriate services to families and children.

Under these circumstances, workers are likely to miss significant elements in assessing child endangerment, fail to make critical home calls, submit late and superficial reports to the court, and clog the paper work flow with errors and overdue corrective actions. This of course will generate more work which in turn will lead to serious and even fatal consequences.

We cannot continue shoving cases on workers and expect them to do the impossible.

Carlos sosa outlined a set of priorities that was helpful.

I would like to suggest the following steps in an effort to help workers survive through this difficult period.

1) Meet with the whole treatment section.
2) Re-emphasize and clarify Carlos list of priorities.
3) Stop asking for explanations of continuances immediately.
4) Stop requesting CSW's to remove children from MCC every time MCC pop reaches a certain number.

5) Request Division Chief to simplify clearing minors into MCC - Allow CSW's to clear minors into MCC as in the command post.

6) Eliminate other paper work requirements temporarily such as submiting and update WICMS with a medi-cal card request.

7) Let the workers know:
    a. That we recognize that their caseloads are way too high and therefore they are not expected to meet all state mandated requirements.
    b. That support systems such as CIS and Foster Care Payments are adding undue stress and work to their already very high and volatile caseloads.
    c. That vacations, sick leaves and other vacancies add even fruther stress and work.

8) Let wokers know what Headquarter is doing if anything to alleviate some of these problems. You may want to invite a VIP from Headquarters to a meeting with the treatment section.

MG:lc

Chairman **Miller**. Thank you. Ms. Johnson.

Ms. **Johnson**. That is a very hard act to follow.

Chairman **Miller**. That is why I deferred to you.

STATEMENT OF LILLIAN JOHNSON, ASSISTANT DIRECTOR, SAN FRANCISCO CITY AND COUNTY FAMILY AND CHILDREN'S SERVICES, SAN FRANCISCO, CA

Ms. **Johnson**. I am very glad that Mr. Ramos spoke before me because it took some of the steam out of my opening comments which I wanted to make in response to Judge Shabo's remarks. As a representative of a public agency in the north, I understand the problems of social services and workers like Mr. Ramos and I want to applaud their efforts.

I am here today to talk about a very small effort on the part of a public social service system, which I think is important—the program talks to what a public agency can do and is doing and asking that legislative leadership look at pilot programs that can be institutionalized in the public social service sector. Then we can do all the things that we have been disparaged for not doing. I think that within the public social service system, we can meet the mandates of the law and show our real concern for parents and their children.

In San Francisco, in January of 1987, we had our first baby with the AIDS virus. This baby had been in the hospital for several months and was not placeable according to anyone's standard at that time. The bill, at that point, had gone to $300,000 and the pressure on the Department to remove this child from the hospital was incredible. The mother, at that point, whereabouts was unknown, in fact, we really did not have any family background.

Late in the time of baby's hospitalization, the mother came on board. The Department was working diligently to try to place this baby; the baby was getting sicker and only because of a small religious community in the north of California, were we able to place this baby. Fortunately we could also find a placement for this mother who is now living very near her baby under the supervision of this small religious community. This sounds like a very happy ending for this family and in some ways, it is. But, the case brought to the attention of management and the community in San Francisco that is this was one of many cases to come.

What we decided to do was we developed a task force of community professionals and lay people who came together under the auspices of social services to look at the issue. We came together to look at how we can limit the hospitalization of these babies, provide maximum home care, allow for consistent caretakers and a medical regime as well as a strong case management from the public sector. Now, this is not to say that we don't believe in preventative services. It is very clear that we could do better if we had a better preventative services system, that if we did more in our reasonable efforts mandate. However despite preventative efforts, there are significant numbers of children that must come into care. They do not have biological families that can care for them. And it is those children to whom I refer.

The primary obstacle in developing a cadre of foster parents that will take drug and AIDS babies and provide the care required for these children *and* allow biological visitation, which is very important in our minds, we decided that these foster parents, *one*, must accept biological parents in their homes which is not something that foster parents have historically done, two, the foster parent cannot work; at least one adult must remain at home at all times. Three: That they attend a multitude of training sessions. We require 30 hours pre-placement of foster parent training for all foster parents. In addition to that, the specialized foster parent then must go through a number of on-going training hours relating to special medical procedures, how our very cumbersome system works, et cetera, et cetera, et cetera. All of this we were asking foster parents to do for $294 a month, in San Francisco and in the State of California. It is absolutely ludicrous to think that anybody would do this for that amount of money.

The department developed a three-tiered payment system based on a special board rate system that we had used a number of years before which allowed for a higher rate of pay for foster parents. Yes, in fact, I think foster parents should be paid and that if they go into it for the purposes of receiving a salary, as long as they provide quality care, I do not blame them for that. Lawyers get paid, I get paid, Congress can get paid, foster parents must be paid.

Then the department developed a system which included a base rate of $294 plus and three levels of care; $900, $1100 and $1400. I think the rate schedule is included in my testimony packet. Included in that, there were other special payments which I will not go into. The Department made a decision that staff would have to be set aside to provide the special level of service to the natural parents, to the babies and to the foster parents. They made a decision to give them limited case load, to provide a coordinator who would then, in fact, develop the program. The program now has been in operation since July of 1987. It is still small and it is growing. We have two full-time child welfare workers on board. We have served 25 babies at this point. Of those babies, 10 have already left the system. As of this morning, we had 15 in our fragile infant care program, five new critically ill babies have been referred in the last three days, two of whom have the AIDS virus.

The program started from an AIDS baby but the fact is that the program has been developed to provide all services to all children with special medical care needs. That includes non-drug addicted babies but most of the babies we are serving are babies who have severe medical problems due to drug addiction.

In order to develop a program of quality with the level of monitoring required, standards should be developed, must be established before funding is allowed. I am not here to say we need more money, just paying higher board rates is not the issue. Money is not the sole criteria for success. The quality of the medical, psychological and social services case management and training support, in our mind, is the key to a successful program. These programs should never be considered a pilot. I realize that the Federal government works on pilot development. Pilots come and go. What we are here to say is that these programs must become an integral part of the public social services system. It is too easy for us to consider specialized programs as frills. When workers have 75 cases and you are sitting next to a worker who is in a specialized program who has 20, it is an impossible work situation. They must be acceptable integrated parts of our social services system.

It seems to me that if we do not include these specialized programs in the social services system, that you talk to the mediocrity in the public social service system that the Judge spoke to and the attorney—I am sorry I do not remember the name. I believe that they are professionals of vision in the public social services system, staff who can develop and provide quality services to children with families and our State and Federal representatives need to support these efforts through creative legislation. The San Francisco Fragile Infant Care program is only a small effort but I believe it illustrates the public social services potential to do the quality of work that we have all spoken of today and without excessive increase in funding.

Thank you.

[Prepared statement of Lillian Johnson follows:]

Prepared Statement of Lillian Johnson, Assistant Director, San Francisco City and County Family and Children's Services, San Francisco, CA

In January 1987, Baby A was in a San Francisco hospital with an HIV positive diagnosis (AIDS). The medical bill was already reaching $300,000 and no one wanted the child. (The mother, also a AIDS victim, was unable to provide a home) S.F.D.S.S. had to find a place. In the care giving community the "fear" of AIDS was at its height. It was virtually impossible to locate an appropriate resource. Fortunately, two years before a small, off the beaten path religious facility, had indicated an interest in taking AIDS children, *if* they became a placement problem. We finally were able to remove the child from the hospital and place the child, as well as move the mother in close proximity to her baby. Sounds like a happy ending, and for the family it was the best of a bad situation. Because of Baby A's case, we began to think ahead as to what happens when the numbers increase. However, we did not focus on HIV positive babies, only, we considered the whole population of children who are the "beneficiaries" of our drug culture.

A task force of community professionals came together under the auspices of Social Services and put together a plan/program that would limit hospitalization time, provide maximum home care, allow for a *consistent* caretaker and medical regime as well as strong/ regular case management from the public sector.

The primary obstacle was the development of a cadre of foster parents that would take babies without regard to the level of care required; allow biological family visitation in their home; not work outside the home; be available to attend all the children's outside medical appointments; attend social services extensive training curriculum (prior to placement of a child and regularly after placement) and the required support and business meetings of the department. It was unlikely the $294 foster care payment for babies would entice the number of foster parents we anticipated were needed.

A specialized recruitment effort was made; an acceptable sliding scale board rate was developed and one staff person assigned to coordinate the task of internal program development.

The program is fully operational at this time and growing, therefore, I will not discuss program details here, however, an overview is attached.

In order to develope a program of quality with the level of monitoring required, program standards should be developed which must be established before funding. It is not enough to pay higher board rates. Money is not the sole criteria for success. The quality of medical, psychological, social service case management and training support is the key to a successful program.

However, these programs should never be considered as a pilot, they must become an integral part of the public system. It is too easy to consider specialized programs as "frills" in social services and this only leads to continued mediocrity in the public system.

There are professionals with vision in the public social service system, staff who can develope and provide quality services to children and families. Our state and federal representatives need to support these efforts through creative legislation. The San Francisco Fragile Infant Care program is only a small effort, but it illustrates the public social service potential, without excessive increase in funding.

LJ:as

FRAGILE INFANT SPECIAL CARE PROGRAM OR "BABY MOMS"

INCREASING NUMBERS OF INFANTS are born with complications from drug or alcohol withdrawal or with positive antibodies for HIV (human immunodeficiency virus). Between 1985 and 1986 San Francisco documented a 50% increase of in-utero neglect due to maternal drug and/or alcohol use during pregnancy. Approximately 20 San Francisco infants each month are in need of specialized medical treatment. As part of a broader effort to serve this group, San Francisco's Department of Social Services has developed the Fragile Infant Special Care Program or "Baby Moms".

"Baby Moms" is the first step in developing a system to address the lack of suitable placement possibilities for the medically fragile infant. Many of these babies were kept in a hospital awaiting placement at a cost of between $425 and $1,200 a day per infant--a costly wait. Even though hospitals provide expert medical care, they may not offer an appropriate nurturing environment for babies with mild to moderate medical problems.

While long-term effects of in-utero drug and alcohol exposure are not fully known, these infants frequently show irritability, tremulousness, microcephaly, hypertonicity, impairment of fine motor control and minor feeding difficulties. Fetal alcohol babies often have long term developmental delays that require participation in an infant stimulation program and neurobehavioral follow-up. Infants with a positive test for AIDS antibodies are another at-risk group. A positive test result does NOT mean that a child has AIDS, but rather that they have been exposed to the virus and need close monitoring. Since their immune systems are possibly deficient, they should not be exposed to potential sources of infection. "Baby Moms" foster parents take special precautions to guard against introducing colds or viruses in their homes and, if there are other children in the home under the age of 7, are asked to serve infants in another risk category.

"Baby Moms" is presently staffed by two social workers with part time support services from a Public Health Nurse, a Neonatologist and a clinical Psychologist. Three levels of infant problems have been defined, and the Neonatologist reviews all potential placements and assigns a baby to an appropriate level of care. Central to the program has been establishing and supporting a County-wide system of referral involving social workers from all the hospitals and the Perinatal AIDS Advisory Committee. Once in the "Baby Moms" home, a case is reviewed medically each month by the Neonatologist to determine if a change in care level is warranted. Special foster care board rates have been established to correspond to the different levels of care. Once the infants are medically stable, permanent placement plans are implemented.

Applicants to become "Baby Moms" provider undergo an intensive screening that includes home interviews and psychometric assessment.

The program is recruiting individuals with prior foster care and/or nursing experience. Once accepted to "Baby Moms", foster parents join a highly skilled group of caregivers and receive regular training that covers relevant medical and psychosocial topics. They also attend a monthly support group and are encouraged to exchange information by phone more frequently which has led to an informal "hot-line" network.

"Baby Moms" now has 12 licensed homes and the current plan calls for 30 homes to be offering services by the end of 1988. In addition to the foster home approach, "Baby Moms" staff are working with an Advisory Committee to develop several group care alternatives as part of the system.

Dated: 4/1/88

April 11, 1988

FRAGILE INFANT SPECIAL CARE PROGRAM

FOSTER CARE RATES 1987/'88

INFANT RATE	$ 294.00	Basic Board Rate
	900.00	Basic Care Supervision Rate
Total. . . .	$1194.00	
INFANT RATE	$ 294.00	Basic Board Rate
	$1100-$1400	*Moderate to Severe Care and Supervision Rate
		*(to be determined by "at-risk" infant medical consultant at time of discharge from hospital or infant medical and care needs increase.
INITIAL CLOTHING (Automatic)	$ 106.00	One time only
RESPITE CARE (50 hrs. per mo.)	$ 4.00/hr.	One time only
	$ 7.00/hr.	Two babies
CHILD CARE (For training & Group Meetings)	$ 4.00/hr.	One baby
	$ 7.00/hr.	Two babies
EXCESSIVE TRAVEL COSTS (Prior approval only)	- Twenty-one cents per mile	
MEDICAL EQUIPMENT (As required & recommended by "at-risk" infant medical consultant)	Actual Cost	
MEDICINES (Not covered by Medi-Cal authorized by "at-risk" infant medical consultant)	Actual cost	

TES WILL BE SUBJECT TO REVIEW AFTER ONE YEAR OF OPERATION.

FRAGILE INFANT SPECIAL CARE PROGRAM
Who Are Our Babies?

April 1, 1988

Since July 1987 when the program opened to the present, the Fragile Infant Special Care program has cared for 25 babies.

Fifteen infants remain in the Fragile Infant Special Care Program where they will be until reunified with their own families or until a permanent placement plan is made. Infants remain in the Fragile Infant Care Program until they are medically stable.

Ten babies have left the program for the following reasons:

- 1 baby has been discharged to therapeutic home for severe emotional disturbance
- 1 baby to long-term foster care
- 1 baby died of AIDS
- 2 to maternal grandparents
- 1 with natural father
- 2 to Fost/opt
- 2 to intact families

Description of Infants Served

Fifteen of these babies had medical complications stemming from maternal drug abuse during pregnancy (principally cocaine, methadon and heroin). Of these thirteen babies four tested HIV positive, one tested viral culture positive and one of these died of AIDS after being in the program two months.

Nine other babies in the program had the following medical problems at the time of admission.

- 16 month-old in a body cast for severe fracture and Hydrocephalia, requiring shunting.
- 24 month-old diagnosed with Hepititis B.
- 20 month-old with a distended rectum due to sexual abuse.
- 11 month-old with Osteo Genesis Imperfects, a chronic bone disease.
- 3 month- old with severe pulmonary distress.
- 9 month-old born with AIDS
- month-old with severe cogential heart deformity and failure to thrive syndrome. (This baby is not expected to live much past her 1st birthday.)

FRAGILE INFANT SPECIAL CARE PROGRAM
Who Are Our Babies?

[illegible]

- Two 6 month-old twins with failure to thrive syndrome.

Five babies have required surgical procedures while in the program. The length of hospital recovery stay averages at two days.

- 1 open heart surgery
- 2 hernia repair
- 1 hydrocephalia requiring shunting
- 1 intestinal sphincter repair

Three babies stayed in the program between 2 and 4 weeks while the foster mothers trained a relative in the special care of these three infants. They were then reunified with their natural families.

STATEMENT OF JUDITH NELSON, EXECUTIVE DIRECTOR, CHILDREN'S BUREAU OF LOS ANGELES, LOS ANGELES, CA

Ms. NELSON. Congressman Miller, thank you for giving me the opportunity to speak to you today. I worked in a couple of other states in similar situations and I happen to know that your job sitting there is much more difficult than ours because you have to listen all day and every day and we appreciate that.

My name is Judy Nelson and I have been the Executive Director of Children's Bureau of Los Angeles, an 84-year old private child welfare agency serving Los Angeles County. The Board of Directors of Children's Bureau has asked me to extend its appreciation to you and members of the Select Committee for their extraordinary efforts on behalf of children and youth in this Country. We deeply appreciate the opportunity to share our knowledge and our concern and our excitement about the kind of programs that we have been able to provide.

With me today have been three staff members including the coordinator of our in-home program, Linda Waters, Sandy Sladen, our Assistant Coordinator and Doctor Jacqueline McCroskey, Professor of Social Work at the University of Southern California, a research consultant for Children's Bureau of Los Angeles. My testimony today will present information about our experience over the past five years providing in-home services to families with young children at risk of child abuse and neglect in LA County.

Very briefly, Children's Bureau serves nearly 5,000 children and family members each year, has a staff of 70 and a budget of approximately 3.5 million dollars.

Its policy is determined by an active volunteer Board of Directors chaired by Wallace W. Booth, Chairman and CEO of Ducommun, Inc. The agency is independently accredited by the Council and Accreditation and the California Association of Services for Children of which I am currently President. Children's Bureau is a multiservice agency providing both treatment and prevention services to young children under 12 and their families. Out-of-home care treatment services include 24 children in group home care, 6 children in emergency shelter care, 50 children in private foster family care and that is growing rapidly, and their families where that is possible.

All of our work is family focused with reunification and/or permanency as our primary goals. Prevention services are provided out of five offices in Los Angeles County, the central or Rampart area, El Monte, Inglewood, Van Nuys and Lancaster. We are particularly appreciative of the public support under Assembly Bill 1733 and 1994 for our effort in these areas made possible by Supervisors Antonovich, Edelman, Hahn and Schabarum and of the collaborative effort with the LA County Department of Children's Services under the leadership of Robert Chaffee.

In the four years in which the prevention program has been in full operation, we have provided in-home and parenting services to over 15,000 children and individual family members and supplemented available public monies by over one million charity dollars representing one-half of the program costs. The provision of extensive charity dollars, including United Way funds, represents in part our commitment to public private collaboration in the provision of needed services but also the unavailability of sufficient public dollars to do this kind of program. The basic staffing model for service delivery is an ethnically sensitive and bi-lingual, where appropriate, team approach. Masters level staff with a paraprofessional. Aggregate data on the clients served between June and December of 1987 may be helpful in developing a sense of the family connection project, our in-home services. Of the 930 individual clients receiving direct service in that 6 month period, 519 were children, 411 were adults. Most families had very young children. 58 percent of all children served were under five years old and almost half of those or 28 percent of the total, were under two. Half of the clients were Hispanic, or 49 percent; 38 percent were caucasian; 9 percent were black; one percent Asian and two percent other. More than half of the clients were referred by public agencies, 43 percent by protective services or other public agencies and an additional 10 percent were court ordered. About half of the cases had experienced no major discern-able abuse and neglect; that is, 52 percent were referred for potential abuse or neglect while 48 percent were referred for actual abuse or neglect. Most referrals were for physical abuse, 57 percent. While 28 percent were for neglect; 13 percent for emotional abuse and 2 percent for sexual abuse.

Let me add a note that those reasons are recorded at intake. The client's admission, as you well know of sexual abuse, may often come later so those figures may not be accurate at the ending assessment. These families are facing very real and difficult stresses. 51 percent reported severe financial difficulty, many with incomes under $10,000 for families with two and three and four children. 50 percent reported heavy child care responsibilities. 43 percent reported fighting and conflict in the household, nearly half. 23 percent reported having a child with unusually demanding characteristics. A situation we know that can trigger abuse and neglect in families without sufficient strengths. One indication of success is the status assigned to the case by the worker at case closing. For 1108 persons during this period, 59 percent could be clearly rated as successes. Of this 59 percent figure, 49 percent successfully completed the program, 10 percent were referred to another agency for long-term treatment of very long-term problems. Success is more difficult to determine for the other 41 percent, 6 of whom moved, 8 percent of whom refused further service and 27 percent who dropped out before completion of the program. This latter number is especially high because workers brought the program to a better shelter during this time period and those who left the shelter before program completion were coded as dropping out. Client satisfaction was very high. Based on a small random sample of 44 clients, all 44 said that they would recommend the program to a friend. 37 said that the program had helped them and 43 expressed their satisfaction with the service. One reporting no feelings. Research is underway.

These and other indicators lead us to believe that the family connection project workers are doing an excellent job with limited resources under very difficult circumstances. Workers go into homes in the worst areas of Los Angeles, they accept all kinds of cases, not just those for whom preventive or early interventive services would traditionally be indicated but also those cases with long histories and current involvement with the Courts and Protective Services. There is no creaming going on. We believe that not only is the program providing high quality services, but it is making an important contribution to developing ideas about the utility of in-home supportive services for all kinds of families. To that end, we are developing practice based evaluative research to help determine with such services are equally effective with all kinds of families and/or problems. For this mixed client group, we need to go much further than just rating success in terms of placement prevention and reduction, although these may be crucially important outcomes in some cases, However, if a child has already been placed, we need to help parents reconnect to that child if possible as well as preventing problems with siblings remaining at home. For the voluntary client or those referred in the early stages of a problem, we need to increase parenting skills, develop parent child relationships and offset the developmental consequences of problematic nurturing. Developing a multi-faceted of outcome indicators is only one part of the research task. Systematic structured client assessment during the first three in-home sessions provides a basis for a realistic treatment plan as well as for later evaluation of complex outcomes.

Perhaps the most important part of the entire process is recognition that data must not only eventually answer the questions of program administrator funders and policymakers, but they must first answer the immediate questions of workers. Is my work in this case effective, am I making any difference. These are very hopeless and we need to answer those questions for workers. Staff are clearly essential to the data gathering process and we put them in an intolerable position when we place paperwork up against service delivery. The paperwork required in this private agency to qualify for public funding currently consumes over half of a workers time. We have designed a research process whose first aim is to improve practice with each client family by structuring assessment linking it to client servicing planning and simplifying paperwork. Workers use an assessment form developed for and by the Family Connection workers at case entry and again, at termination in place of making lengthy case notes. The workers reactions define a crucial variable of success. They report that this form not only makes recording easier, but it makes them think systematically about complex cases, treatment goals and service delivery methods. Pilot data from the initial analysis of these forms indicates that the program is making significant difference in the lives of many families with young children. More data will be available within the next year which we would, of course, be pleased to share.

Some thoughts and conclusion. Our experience and our initial data clearly indicate a cost effective rationale for providing prevention services in the clients home. Our costs per year per client family is under $1800 per year in this program. Yet, incentives and funding for in-home preventative services in serious practice based research in child welfare is seriously lacking and in many cases, non-existent. More data is needed to understand causation and to demonstrate cost effectiveness in our efforts. In addition, the remarks earlier about blended funding should apply to blended programs and blended research so that we stop labelling children and start serving them where their needs are. I am pleased to report that Children's Bureau has recently been awarded a grant of nearly $700,000 from the Stuart Foundation to expand our research in this area and to increase our outreach to the Inglewood community. We will be pleased to share that data with you as it develops over the next three years. Thank you for allowing us to share our experience today, our preliminary research findings and our suggestions. We strongly urge you to continue and expand your very commendable efforts to promote prevention services to this population. It is vital that public policy catch up with this tremendous need which can only worsen without adequate attention. If we can be of further assistance, we would be pleased to work with you on our similar goals. If there were time permitting I could share with you some testimony a client was going to present that could not be with us today and there are other issues but I think I will close with that.

[Prepared statement of Judith Nelson follows:]

PREPARED STATEMENT OF JUDITH NELSON, ACSW, J.D. EXECUTIVE DIRECTOR, CHILDREN'S BUREAU OF LOS ANGELES, LOS ANGELES, CA

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TESTIMONY

House Select Committee on
Children, Youth and Families

April 15, 1988

I. INTRODUCTION

Congressman Miller and Distinguished Members of the Committee:

My name is Judy Nelson, Executive Director of Children's Bureau of Los Angeles, and I am grateful for the opportunity to speak to you today.

Children's Bureau of Los Angeles (CBLA) is a nonprofit, non-sectarian child welfare agency which was created in 1904. The agency specializes in treatment and prevention services for at-risk and/or abused and neglected young children ages birth to 12 and their families. The treatment program includes 50 children in therapeutic foster care, 24 children in community-based family-centered group homes (children ages 4-12), and 6 children in shelter care (ages birth through 4). All children in residential care are tested for developmental delays. Developmental remediation is provided where appropriate.

Prevention services are provided in five locations throughout Los Angeles County in the homes of over 250 children and family members each month. Special emphasis is placed on providing services to client groups and communities where the need is high and the availability of services is relatively low.

Major outreach in the last few years has resulted in a high percentage of minority clients served, particularly Hispanics, with bilingual and bicultural staff where appropriate. Due in large part to major funding recently awarded by the Stuart Foundations (a 3 year grant of $657,000), the agency will be expanding its outreach to the black and hispanic populations in the Inglewood community and its research effort. Once that program is well under way, consideration will be given to expanding services to the Asian community.

Currently the agency has a staff of approximately 70 people. The proposed budget for fiscal year 88-89 is approximately 3.5 million dollars. The agency is governed by a volunteer Board of Directors, chaired by the CEO of Ducommun, Inc., Wallace W. Booth. As Executive Director for the last eight years, I bring to the agency a background in both law and social science, as well as extensive experience working with children and families, as a prosecutor in juvenile court, a welfare case worker, a state agency administrator, relief houseparent and a legislative aide.

The basic mission of the Children's Bureau of Los Angeles is to provide the highest quality treatment and prevention services to young children and their families. More recently, the agency has focused, in addition, on practice-based research, designed to further knowledge about the field and to impact public policy affecting children and their families.

I have been asked by the Board of Directors of Children's Bureau of Los Angeles to commend Congressman Miller and members of the Committee for the exceptional commitment and leadership being provided through the Committee's work. We are pleased to have an opportunity to contribute to this important effort.

A. Purpose

My purpose today is to describe for the Committee the efforts and impact of the in-home prevention services we created over four years ago. I would like to do so in the context of the total agency services because in our years of experience we have learned that prevention and treatment cannot be separated; that, in fact, placement can be and very often is a form of prevention and that not all efforts at preventing placement are necessarily successful prevention. In addition, we are convinced that there are times when out-of-home placement is the treatment of choice, or should be. As an agency that provides both treatment and prevention, we are in a position, if given the opportunity, to select the best approach for the child and his family based on the circumstances in which we find them. Too often, the system will not permit this luxury. Instead, because of single funding streams, labeled children and restrictive policies, the prevention door has already been closed by the time placement is ordered or the opportunity for intervention with the family has died.

Having sat as an ex officio member of a State legislative committee studying the needs of young children some years ago, I am keenly aware of the magnitude of your task. It is my goal to help make your task easier by bringing as many pertinent facts and figures as we have available. However, I do so with the caveat that as you are aware, hard data in the child welfare field generally, and particularly in prevention, is hard to come by. Our "research" has been primarily anectodal. This is the case because the variables affecting the lives of children and families are so astoundingly complex. In addition, incentives and funding for serious practice-based research in child welfare is seriously lacking and, in many cases, nonexistent. It must also be made clear that because we at Children's Bureau view child abuse and neglect in the broader context of child welfare, we are searching for success criteria other than just placement or lack thereof. We feel strongly that quality of life for the child, wherever he or she is, must be the first criteria for success and that placement is but one of many issues on a continuum of success indicators.

B. Research Overview

Dr. Jacquelyn McCroskey, Professor of Social Work at the University of Southern California, has been assisting Children's Bureau of Los Angeles with its practice-based research for the lat two years. We are extremely fortunate to have her services because of her talents in both service delivery and in social service research. Dr. McCroskey brings an invaluable combination to a relatively traditional child welfare agency. She speaks the language and provides critical support to the workers who have to provide these very difficult services; yet she is able to assist those workers to learn the research vocabulary and the discipline essential to produce valid, significant data.

C. Financial Support

In its initial research efforts, the agency received some financial support from the W.M. Keck Foundation and other private monies. Partial funding for the in-home services themselves came from a variety of sources, including United Way. The initial grant came from the State of California through Assembly Bill 1733, which funded two of the agency's five programs in in-home services in the fall of 1983. A second grant was later received through Assembly Bill 2994, which represents the proceeds from the trust fund set up for additional birth certificate monies. However, no public funding was available either on an ongoing basis or in an amount sufficient to pay for any more than half of a quality service program. Charitable dollars have subsidized the other half. Without the charitable dollars and the agency's backup, a quality program would not have been possible.

With all due respect to those who have struggled so hard to make Assembly Bill 1733 and 2994 work, the inordinate paperwork and regulations that have accompanied those funds basically represented a test for survival of those who could best do paperwork.

While the original intent was to require accountability and to develop substantiating data, the impact has been 1) unnecessary overload of workers already overloaded by a nearly impossible job, and 2) the production of numbers reflecting primarily quantity rather than quality. Little feedback is provided to the agency in return for countless hours of paperwork, often well exceeding 50-60% of a worker's time.

In large part, Children's Bureau of Los Angeles initiated its research effort in an attempt to get at the quality issues and to see if there was not a better, less costly way not only to be accountable, but to discover information that would lead to improving services. We believe we are on the way to accomplishing that task. Allow me to share our beginnings with the Committee today.

II. PROGRAM BACKGROUND

CBLA has worked in the area of child abuse and neglect treatment and prevention since the turn of the century. One of the most significant and growing obstacles encountered by CBLA in working with children and families lies in the separation of services and jurisdictions in this large multicentered metropolis.

Responding to identified needs, CBLA has built a comprehensive continuum of services for children and families. To bring services to families and to reach families earlier, CBLA enhanced its treatment program with the addition in 1983 of its community based in-home prevention program, the Family Connection Project (FCP). The integration of this program with the Agency's treatment services has also allowed for family work with children in placement with the agency and follow-up work to help stabilize newly reunified families. Coordination of the FCP program has been provided by Linda Waters.

Our initial five years of operation of this program have provided a wealth of information and practical experience. Initially, we were inclined to define brief service in units of six to eight weeks. Through our experience with a client population characterized largely by poverty, isolation and extremely complex problems, it has become clear that we need to plan for a minimum of 12 to 16 weeks of service.

Originally, parenting was viewed as a set of skills that could be taught or corrected primarily through an educational process. While parenting skills remain important, it has been demonstrated that the lowering of environmental risk factors for children is much more dependent upon the parent-child relationship. We now understand parenting as participation in a complex, highly emotional relationship that is strongly based in individual and family psychology and less as the exercise of a set of learned skills. Therefore the focus of the program is on strengthening the parent-child relationship.

In the future our client count may be somewhat reduced, but the units of service being delivered will remain substantial as our workers concentrate their efforts on addressing the complex problems the families bring. In effect, the program will continue to serve as a family support system with families reactivating their "connection" in times of crisis.

Our agency's capability for providing services to minority populations is reflected in the FCP statistics. For the year of 1987, of the 2,400 people served, 66% were members of minority populations. Within a given area every effort is made for the provision of staff from various ethnic groups to be consistent with the population served. For example, the Los Angeles County Department of Regional Planning 1980 Census indicates that the Latino population in the San Gabriel Valley area (Sup. Dist. I) ranges from approximately 60% to approximately 75%. Therefore the staff in the El Monte office servicing this area are 75% Latino (bilingual/bicultural). The same is true for the other four districts. Full time direct service staff currently consist of two Blacks, four Hispanics and four Caucasians, five of whom are bilingual Spanish-speaking, with one additional position unfilled.

The Children's Bureau has made an ongoing commitment to our Child Abuse and Neglect Prevention program called the Family Connection Project. Since its inception in 1984 the Children's Bureau has contributed over $1,000,000 in matching funds, representing approximately 50% of total budget. During the upcoming 1988-89 fiscal year CBLA anticipates providing over $441,000 in matching funds based on the funding request we are submitting.

		IS FUNDING	######################		AMOUNT	######################	
FUNDING SOURCE	PROGRAM TITLE	ONGOING	1982-83	1983-84	1984-85	1985-86	1986-87
SPECIAL EVENTS		YES		$40,862	$55,982	$154,461	176663
CONTRIBUTIONS		YES	$196,318	$135,181	$112,681	$96,780	125056
AFDC-FC	THERAPEUTIC GROUP HOME	YES	$360,727	$446,279	$495,314	$491,671	509310
AFDC-FC	FAMILY CRISIS CENTER	YES	$83,100	$36,062	$86,555	$75,482	127140
AFDC-FC	FOSTER CARE	YES	$145,893	$190,202	$179,012	$206,108	301655
.733/AB2994	FAMILY CONNECTION PROJECT	UNKNOWN	$0	$107,575	$194,025	$308,258	319876
INVESTMENT INCOME		YES	$3,200	$7,877	$7,387	$11,743	17624
UNITED WAY		YES	$374,348	$407,724	$475,584	$501,463	558729
MISCELLANEOUS		YES	$2,956	$455	$1,785	$1,029	792
			$1,166,542	$1,372,217	$1,608,325	$1,846,996	$2,136,871

III. IN-HOME PREVENTION PROGRAM

The program is a comprehensive child abuse and neglect prevention and early intervention family support program. The service activities for the program are provided at five community-based locations: El Monte (Sup. Dist. I), Inglewood (Sup. Dist. II), Central Los Angeles (Sup. Dist. III), and Van Nuys and Lancaster (Sup. Dist. V).

A. Target Population

Targeted clients are families or caretakers, including foster parents, with children under the age of 12 who are high-risk for child abuse or neglect or possible out-of-home placement of one or more children. Based on 1987 statistical data on clients we would expect the following demographic percentages in each district:

1) Supervisoral Dist. I/El Monte

Age	%	Ethnicity Culture	%	Sex	%	Referral Source	%
Children:							
0-2	24						
#3-5	25						
6-8	28	Black	5	Adults:			
9-11	17			Male	38	Self	13
12-14	5			Female	62		
15-18	1	Cauc.	16				
						DCS/	
Adults:				Children:		Court	54
-17	2	++Hispanic	75	Male	53		
18-24	16			Female	47		
25-29	33					**Other	
30-39	35	Asian/				Mandated	
40-49	13	Other	4			Reporters	33
50+	1						

** Law enforcement, schools, medical and other nonprofit agencies
# 77% of children under 8; 49% under 5
++ 75% of clients Hispanic

2) Supervisoral District II/Inglewood

Age	%	Ethnicity Culture	%	Sex	%	Referral Source	%
Children:							
0-2	37						
#3-5	37						
6-8	12	Black	45	Adults:			
9-11	11			Male	25	Self	13
12-14	2			Female	75		
15-18	1	Cauc.	16			DCS/	
Adults:				Children:		Court	55
-17	2	Hispanic	36	Male	53		
18-24	14			Female	47		
25-29	32					**Other	
30-39	45	Asian/				Mandated	
40-49	5	Other	3			Reporters	32
50+	2						

** Law enforcement, schools, medical and other nonprofit agencies
# 86% of children under 8; 74% under 5

3) Supervisoral Dist.III/Central Los Angeles

Age	%	Ethnicity Culture	%	Sex	%	Referral Source	%
Children:							
0-2	27						
3-5	24						
6-8	22	Black	6	Adults:			
9-11	16			Male	21	Self	8
12-14	7			Female	79		
15-18	4	Cauc.	13				
						DCS/	
Adults:				Children:		Court	52
-17	1	++Hispanic	75	Male	55		
18-24	15			Female	45		
25-29	31					**Other	
30-39	38	Asian/				Mandated	
40-49	13	Other	6			Reporters	40
50+	2						

** Law enforcement, schools, medical and other nonprofit agencies
# 73% of children under 8; 51% under 5
++ 75% of clients Hispanic

4) Supervisoral Dist. V
a. Van Nuys

Age	%	Ethnicity Culture	%	Sex	%	Referral Source	%
Children:							
0-2	22						
#3-5	40						
6-8	18	Black	3	Adults:			
9-11	14			Male	32	Self	8
12-14	6			Female	68		
15-18		Cauc.	55				
						DCS/	
Adults:				Children:		Court	81
-17		Hispanic	40	Male	39		
18-24	32			Female	61		
25-29	21					**Other	
30-39	27	Asian/				Mandated	
40-49	5	Other	2			Reporters	11
50+	15						

** Law enforcement, schools, medical and other nonprofit agencies
# 80% of children less than 8; 62% less than 5

5) b. Lancaster

Age	%	Ethnicity Culture	%	Sex	%	Referral Source	%
Children:							
0-2	32						
#3-5	34						
6-8	17	Black	8	Adults:			
9-11	10			Male	16	Self	7
12-14	4			Female	84		
15-18	3	Cauc.	82				
Adults:				Children:		DCS/ Court	32
-17	2	Hispanic	8	Male	45		
18-24	22			Female	55		
25-29	31						
30-39	35						
40-49	8	Asian/ Other	2			**Other Mandated Reporters	61
50+	2						

** Law enforcement, schools, medical and other nonprofit agencies
# 83% of children under 8; 66% under 5

Historically, in the FCP experience, family stressors predominantly fall into six major categories. Financial difficulties seem related to both lack of monies and poor ability to manage monies. Fighting and conflict in the home appear to be reflective of poor problem-solving and communication skills. Isolation from social supports and extended family is a common theme. Feeling overwhelmed by child care responsibility appears frequently in single parent families, families with young parents, parents with several children and parents of special needs children. Problems of substance abuse were involved in over half the cases. Issues stemming from cultural adjustment were reported frequently in El Monte (Sup. Dist. I) and Central Los Angeles (Sup. Dist. III), but only occasionally in Inglewood (Sup. Dist. II) and were not reported in Van Nuys and Lancaster (Sup. Dist. V).

Our experience indicates that client families tend to be multiproblemed, isolated and non-users of traditional helping services. They often lack the skills necessary to link with needed community resources or to navigate service systems. Frequently there is little awareness of the impact parental behavior and choices have on children or the family system. Often issues of poor impulse control combine with ineffective methods of coping with high stress to result in abuse and family disruption. These parents' self-esteem often depends upon their children. This factor added to their unrealistic parental expectations and poorunderstanding of child development results in troubled parent-child relationships. The parents' own depression or feelings of defeat and helplessness may render the parents emotionally unavailable and insensitive to the child's developmental and emotional needs. Child rearing in these families is perceived as only an irritation or chore with little pleasure, thus making children highly vulnerable to abuse and/or neglect.

The issues seen in the targeted families as discussed above do not work independently of one another. They combine in various patterns that result in poor child care skills and abilities, troubled parent-child relationships and children at high risk.

B. Program Description

The needs of the target population have been identified by the psychological profile based on past experience, the family stressors named, and the demographics. To serve these families and their children effectively a prevention and intervention approach is required which:

1) helps client access needed services
2) empowers the adult as both an individual and a parent
3) supports and builds self-esteem
4) confronts reality in a realistic partializing and problem-solving way
5) helps the adult to make cause-effect connections
6) builds daily living and coping skills
7) addresses isolation by helping people to learn ways to access, build and utilize social and community supports
8) provides parenting guidance and knowledge relating to child development and realistic expectations about children
9) provides learning in a three-dimensional way rather than being dependent upon the client's verbal skills or ability for insight
10) addresses communication and conflict resolution within the family

One of the more crucial needs for these parents is to find some pleasure in parenting so that the effort it takes to change past habits and to learn and maintain new skills can be sustained.

In addition to the above, programs sensitive to minority populations are needed in El Monte (Sup. Dist. I), Inglewood (Sup. Dist. II) and Central Los Angeles (Supt. Dist. III), with bilingual capabilities especially needed in El Monte and Central Los Angeles. There appears to be a growing need for bilingual services in the Van Nuys area of Supervisoral Dist. V but little minority need in the Lancaster area.

The program is designed and implemented to meet the needs of the target population in several ways. Offices in Inglewood (Sup. Dist. II), Central Los Angeles (Supt. Dist. III), Van Nuys and Lancaster (Sup. Dist. V) will be staffed with a team consisting of two Family Response Workers (FRW) and one Case Aide. The El Monte (Supt. Dist. I) office will be staffed with two teams of two Family Response Workers and a Case Aide. All teams would be under the direct supervision of a Licensed Clinical Social Worker (LCSW).

Program sites are selected that encourage client accessibility, although most work is done in-home. Services, such as parenting groups, are conducted in local daycare and community centers, schools, Headstart programs, churchs, etc. In Sup. Dist. V, services are provided from two community-based sites allowing for greater client access.

All services, provided at no cost to the client family, will be provided by ethnically, culturally and linguistically appropriate staff. Twenty-four hour accessability will be maintained as additional support during emergency situations. Reports will be provided to appropriate public agencies regarding client problems and progress. Contact with high-risk families will be initiated through networking with other service providers and community awareness presentations.

Intake screening will be provided on the phone or in person to initiate appropriate services. Every effort is made to respond in a timely manner to the initial referral. Clients are contacted verbally within one week and seen in-person within two weeks. If there is a waiting list, families are immediately linked with other appropriate agencies. Any family coming into contact with the program will be provided appropriate referrals and helped to get needed services not provided by this agency. Family Response Workers go into the family's home to do a psychosocial assessment to determine the type and direction of services and to establish therapeutic goals and methods for the case plan. Developmental assessments will be completed on preschool age children to detect early signs of special needs or problems. To gain a fuller understanding and to ensure the most effective treatment approach, services are coordinated with other concerned professionals, such as schools, DCS, medical services, etc. Subsequent home visits will be structured to permit counseling, modeling of positive relationships and effective child-rearing techniques and to demonstrate homemaking and home maintenance skills. Simultaneously, clients will be encouraged to participate in specialized parent support groups offering educational guidance and training. As a back-up service for client families, emergency respite care will be provided to reduce stress in situations where the parent is requesting temporary relief. Most services will be provided in the home, however transportation and transportation monies will be available to support other services.

The services provided are counseling and home-based services. Some respite care and transportation will also be provided. Child care during parent support groups will be subcontracted.

Reduction and prevention of child abuse and neglect occurs in several ways. Over half of the children served are under five and three-fourths are under eight. This means that high-risk factors are detected at a point in the parent-child relationship before they become ingrained negative patterns and while they are more amenable to intervention. Families with special needs children are identified and receive treatment earlier. Factors, such as isolation, that are associated with high-risk families are addressed. The parents' ability to cope with stress and anger, to problem solve and find more effective options and to function on a daily basis is increased. As parents feel less helpless and defeated they are less likely to vent frustrations on their children and more able to be protective. When family relationships and communications improve and become stronger and parents experience some pleasure in parenting, the risk decreases. This more positive approach reduces the tension in the child and allows them to listen and learn, which serves to confirm parents' efforts. With increased self-esteem and new parenting knowledge, the parent's self-worth is no longer totally dependent on the child. By creating a respite system within the parent support group for sharing child care the decision-making power remains with the parent. Parents are encouraged to practice building and utilizing informal social supports, thus bringing informal and formal support systems together. Families who have developed a support network in the community and know how to access resources have more appropriate options available to them during times of stress. Counseling and skills-building allow the parent to learn experientially, increasing the likelihood of maintaining changes.

The number of persons to receive services would be 384 per funded team. For the fiscal year 1988-89, this would total 2,304 persons served programwide. (These figures do not include the numbers in the proposal recently funded by the Stuart Foundations. See Appendix 4.)

Location	Number of funded teams	Persons served per District
1) Sup. Dist. I/El Monte	2	768
2) Sup. Dist. II/Inglewood	1	384
3) Sup. Dist. III/Central L.A.	1	384
4) Sup. Dist. V/Van Nuys		
Lancaster	2	768

IV. WORK NARRATIVE JULY 1, 1988 - JUNE 30, 1989

GOAL: To reduce the risk and incidence of child abuse and neglect by helping parents in high-risk families assume a more responsible and responsive parenting role. Simultaneously, to reduce the numbers of children placed out-of-home. Note: This program has been operational since October, 1984. All services will be in effect July 1,1988.

Objective:	Service Activities Units of Measure	Minimum Units per worker per month	of Service per team 12-mo. ttl.	Service Activity Conducted By
		Counseling:*		Family Response Worker (licensed and unlicensed professionals)
	Individual - Adlt/Chld	60 min	92	
1) To strengthen parent-child relationships, facilitate parents supporting each other and improve family communication.	Family - Related	60 min	24	
	Group - Unrelated	90 min	120	
	Child Therapy	30 min	6	
2) To build self-esteem, raise self-awareness and understanding, improve and develop problem-solving and coping skills.				
3) To defuse crises and solve problems Case Aide leading to or contributing to child abuse and neglect.	Home-Based Service:			
	In-home Counseling	60 min	432	(paraprofessional staff)
	Individual	60 min	244	
	Family			
4) To decrease isolation and increase parenting skills and knowledge.				
5) To improve and teach basic parent skills, establishing realistic parental expectations related to child development.	Teaching and Demonstrating Homemaking	60 min	208	Case Aid (paraprofessional) staff)
6) To assist families with day-to-day functioning, including locating and linking with resources.				
7) To provide temporary relief from parental duties so that the parenter can participate in in-home counseling.	Temporary In-home Caretaking	60 min	100	
8) To alleviate stresses related to daily child care and to allow temporary relief from parental duties in 4-hour increments.			208 hrs.	Arrangements made by parents and paid for by redeemable Agency vouchers
9) To provide temporary relief from parental duties so that the parenter is able to fulfill other responsibilities necessary to improve or maintain their parenting function, in emergency situations up to 72 hours.	Respite Care	4 hrs	864 hrs.	CBLA's certified foster care homes
10) To provide emergency temporary child care when the parent is absent or incapacitated.				
11) To provide respite care which improves a child's developmental functioning.	Therapeutic Respite Care	30 min	864 hrs.	CBLA Family Crisis Center
12) To support other services and assure continuity of services.	Transportation	15 min	208 hrs.	Case Aide Monies provided for bus, gas, etc.

*Minimum service standard as defined by the Department of Children's Services request for proposal.

V. MONITORING AND EVALUATION

Quality of services and cost effectiveness is monitored and evaluated in a variety of ways. The program coordinator: 1) provides bi-monthly on-site supervision, including monitoring case files, case plans and case loads; 2) goes in-home with staff on a regular basis to supervise worker-client sessions; 3) provides bi-monthly team and group supervision/training; and 4) conducts regularly scheduled individual performance evaluations for program staff. Family and individual functioning (for example, the Developmental Profile) is determined in part by tests conducted by outside consultants.

Staff will complete standardized assessments of parental functioning when treatment objectives are established and again when treatment is terminated. This will indicate changes in parental functioning and assess the attainment of treatment objectives. At case closing, parenters will be asked to complete a service evaluation form anonymously to gain feedback on client satisfaction. A further check to assure program quality will be periodically conducted by a CBLA staff person other than FCP staff. This will entail a regularly scheduled evaluation of case files to verify that necessary treatment components are provided. Monthly work sheets will be maintained by each team member to record type of and dates of services received by each client family. These work sheets will be monitored by the program coordinator. They will track and verify the attainment of numerical units of service objectives. The documents used for monitoring and evaluation are attached following the job descriptions.

CBLA will monitor program cost effectiveness by monthly review of program expenditures and employee activity sheets. Both program coordinators and fiscal management staff will meet at least once monthly to review budget fluctuations in expenditures, evaluate bids for goods and services and monitor employee effectiveness in accomplishing established units of service goals. Program coordinator will then meet with individual staff to help establish more effective methods of meeting goals. Group staff training meetings will be used to identify and teach techniques used by effective producers and these techniques will be incorporated into the program.

Funding has been requested from AB 1733 and AB 2994 in a recent Request for Proposal (RFP) to Los Angeles County. One full-time team each in Supervisorial District II (Inglewood) and Supervisorial District III (Central L.A.) has been requested. Two funded teams were requested in Supervisorial District I (El Monte) and Supervisorial District V (Van Nuys and Lancaster). Whenever possible a team will consist of a person with a Bachelor's level degree with experience matched with a staff person having a Master's degree in the behavioral sciences. Case Aide selection would be based on parenting experience and knowledge and ability to empathize with parental struggles. The

Case Aide will not be required to have a degree. In addition, every effort will be made to staff teams that represent the cultural, ethnic and linguistic composition of the community.

Currently 9 full-time, three half-time (one Family Response Worker/Supervisor and two Case Aide/secretaries) and one quarter-time treatment staff positions exist in the program. In El Monte, all staff are bilingual Spanish-speaking and three are bi-cultural Hispanic. Both Inglewood staff are Black. In Central Los Angeles, one Family Response Worker is bilingual/bicultural Hispanic and one position is unfilled. Currently in Van Nuys, the one and one-quarter funded positions are filled by Caucasians as are the positions in Lancaster. This pattern represents the client statistics for each area and the ethnic, cultural and linguistic demographics pattern.

VI. RESEARCH FINDINGS

A. Aggregate Data

Aggregate data on the clients served between June and December last year (1987) may be helpful in developing a sense of the Family Connection Project.

0 of the 930 individual clients served, 519 were children and 411 were adults.

0 Most families had young children: 58% of all children served were under five years old and almost half of those (28% of the total) were under two years old.

0 Half of the clients were Hispanic (49%); 38% were Caucasian; 9% were Black; 1% were Asian and 2% were other.

0 More than half of the clients were referred by public agencies: 43% by protective services or other public agencies and an additional 10% were court ordered.

0 Only about half of the cases were "preventive"; 52% were referred for potential abuse or neglect while 48% were referred for actual abuse or neglect.

0 Most referrals were for physical abuse (57%), while 28% were for neglect, 13% for emotional abuse and 2% for sexual abuse (Note: these are recorded at intake, and admission of sexual abuse often comes up later.)

0 Families face very real and difficult stresses: 51% reported severe financial difficulties, 50% reported heavy child care responsibilities, 43% reported fighting and conflict in the household and 23% reported having a child with unusually demanding characteristics.

- One indication of "success" is the status assigned to the case by the worker at case closing; for 1108 persons during this period, 59% could be clearly rated as "successes"; 49% successfully completed the program and 10% were referred to another agency for long term treatment. Success is more difficult to determine for the other 39%, 6% of whom moved, 8% of whom refused further service and 39% who dropped out before completion of the program. This latter number is especially high because workers brought the program to a battered women's shelter during this time period and those who left the shelter before program completion were coded as "dropping out".

- Client satisfaction was very high, based on a small sample of 44 clients; all 44 said that they would recommend the program to a friend; 37 said that the program had helped them and 43 expressed their satisfaction with the service (one reported no feelings.)

B. Research Underway

These and other indicators lead us to believe that the FCP workers are doing a good job with limited resources under very difficult circumstances. Workers go into homes in the worst areas of Los Angeles; they accept all kinds of cases, not just those for whom preventive or early interventive services would traditionally be indicated, but those with long histories and current involvement with the courts and protective services. There is no "creaming" going on. We believe that not only is the program providing high quality services, but it is making an important contribution to developing ideas about the utility of in-home supportive services for all kinds of families.

To that end, we are developing practice-based evaluative research to help determine whether such services are equally effective with all kinds of families and/or problems. For this mixed client group, we need to go much further than just rating success in terms of placement prevention and reduction, although these may be crucially important outcomes in some cases. However, if a child has already been placed, we need to help parents reconnect to that child if possible, as well as preventing problems with siblings remaining at home. For the voluntary client or those referred in the early stages of a problem, we need to increase parenting skills, develop parent-child relationships and offset the developmental consequences of problemmatic nuture.

Developing a multifaceted set of outcome indicators is only one part of the research task. Systematic structured client assessment during the first three in-home sessions provides the basis for a realistic treatment plan, as well as for later evaluation of complex outcomes.

Perhaps the most important part of the entire process is recognition that data must not only eventually answer the questions of program administrators, funders and policy makers, but they must first answer the immediate questions of workers. Is my work in this case effective? Am I making any difference? Staff are clearly essential to the data-gathering process and we put them in an intolerable position when we place paperwork up against service delivery. We have designed a research process whose first aim is to improve practice with each client family by structuring assessment, linking it to client service planning, and simplifying paperwork. Workers use an assessment form developed for and by FCP workers at case entry and again at termination, in place of lengthy case notes. The workers' reactions define a crucial variable of "success"; they report that this form not only makes recording easier, but it makes them think systematically about complex cases, treatment goals and service delivery methods. Pilot data from an initial analysis of these forms indicates that the program is making a significant difference in the lives of many families with young children. More data will be available within the next year.

VII. ISSUES AND RECOMMENDATIONS

Based on nearly five years of experience with in-home preventive services and eighty four years of providing quality child welfare services in the Southern California community, we offer the following observations and recommendations.

At the risk of repetition, stable, flexible funding for ongoing services remains the primary issue. As a private agency dependent on volunteer fund raising efforts, it is very difficult for us to commit to initiate and develop extensive service efforts without some knowledge that there is a parallel public sector commitment.

Other key issues are closely related to funding. Staffing of in-home services is an ongoing concern. Because this work is so difficult and takes so much skill and durability, qualified workers are very hard to find. This is complicated when we are unable to pay salaries equivalent to those paid in the public sector or even to comparable programs, due to limited availability of funding. In addition, because of funding restrictions and inflexibility, we are often unable to apply the knowledge we have gained over the years.

For example, we know from experience that "burnout" for workers providing services to high-risk families in their own homes is even higher than it is in other aspects of child welfare service delivery. This is due to the extreme poverty, deprivation, and very often unclean and unsafe conditions that workers have to face every day. Yet the numbers we have had to commit to, in order to secure public funding, do not permit us to relieve these workers with other kinds of cases or experiences. Therefore, turnover among in-home staff is relatively high, representing a loss not only of staff time and performance but of training time and energy as well.

Further, we must burden these already burdened workers with unreasonable paperwork demands, forcing workers to choose paper over people in need. A reduction of the paperwork, a reevaluation of what we want to know, and regular analysis and feedback at a state and national level are all essential steps that must be taken if the commitment to preventive services is to stay alive.

In recent years, special interests such as child sexual abuse, infant abuse, domestic violence, alcohol abuse, drug abuse, foster care, residential care, and psychiatric care all seem to have developed into specialties of their own, with little linkage of issues and efforts that cannot be separated. For example, the impact of alcohol and drugs on families with abuse and neglect tendencies is rampant in our caseloads. Yet we are in many ways competitive with substance abuse programs for funds and little shared programming exists.

Strong encouragement must be established for collaborative efforts to reduce competition between services and agencies. In addition, in order for us to focus on what really works, what is acutally cost effective, incentives must be created for research at all levels. Longitudinal research is essential so that we can take a broader view of the impact of our services. While our research answers are limited, our questions are not. Further, all research in the child welfare field should be directed to qualitative as well as quantitative issues.

Dr. James Whittaker of the University of Washington, a noted researcher in our field, has demonstrated that even minimal work with families of children in out-of-home care can have a major impact on reunification efforts as mandated by Public Law 96-273. There is a critical need to integrate the research in out of home care with what we know and need to know about children in their own homes.

For example, how much family work is needed to have an impact on families in their own homes? Which families respond best to which techniques? And a question I am most keenly interested in: how far back do we need to go with families to be effective? Why do we have to wait until placement is imminent for services to be delivered? What damage to the child and family relationships could be prevented by early intervention and with what impact and at what cost savings? The list of unanswered questions is endless. We must begin now to address the key questions so that our effort will be directed towards cost effective results.

The issue of support for families is another that has extensive anecdotal data and little research-based facts. What is the need for, and/or impact of, respite care? Who should provide it and with what standards? What are the risk issues? Is is really the "answer" as we seem to be hearing? How big a factor is isolation for abusive families? How much support do they need? Is part of the "answer" a return to the Hull House concept of neighborhood support? Again, more questions needing thoughtful study and research.

Regarding research efforts in social services, there needs to be a greater understanding of the difficulties for agencies to implement such research, even where there is high incentive and commitment. It has taken us months to make even minimal progress in developing a research model. The effort requires retraining, reorientation plus unavailable time and dollars to create the investment, the knowledge, the skill and the patience for even basic data collection to be done which is accurate, objective, comparable, collectable, codable, understandable and/or usable.

You have heard a description of our current prevention program, called the Family Connection Project, and our plans for the coming year, if funded. The Stuart Foundations grant, referenced earlier, will permit the expansion of the prevention effort in the Inglewood community of Los Angeles through two additional teams, plus support. In addition, a major research component is planned which will be conducted in conjunction with a similar program provided by Hathaway Children's Center. Such interagency collaboration in research is relatively rare and we see this as a very special opportunity to test out some of our hypotheses about what might work, based on very sound experience. However, the private sector cannot be expected and, in fact, is not capable of funding the core provision of prevention services. We believe, and our track record would support, the concept of the marriage of the public and private dollar in the provision of prevention services to at-risk families. However, to date the partnership has tended to be one-sided; we would welcome company in this effort.

Certainly many elements of the public sector, specifically the Los Angeles County Department of Children's Services, under the leadership of Robert Chaffee, have demonstrated an interest and strong support for the concept of prevention. However, without national and state leadership such support can be translated into concrete programming at only a minimal level.

In summary, we would like the Committee to hear that while there are barriers and disincentives to providing prevention services to children and familes at risk of abuse and neglect, we believe that if we do not continue to search for cost effective means of earlier intervention and prevention, we are indeed part of the problem. The use of extensive charity dollars, volunteer hours, expertise and resources towards achieving this goal by Children's Bureau of Los Angeles and a growing number of other agencies is a testimony to our commitment. In order for us to continue and expand that effort, we urgently need at least an equivalent commitment at the state and national levels.

Such a commitment could be minimally demonstrated by leadership in identifying the current state of knowledge of effective child abuse and neglect services, in the context of child welfare; by encouragement for public/private collaboration; by incentives for research and creative programming; by reduction of legislative and administrative barriers; by promotion of blended funding streams that work towards reducing or eliminating the labeling of children and the "turfdom" of services.

Again, we wish to commend the Select Committee Chairman and its members for their leadership, their commitment and their willingness to ask and to listen. We at Children's Bureau of Los Angeles are grateful for the opportunity to be heard.

APPENDIX

1. Agency Description

2. Representative Letters of Support

3. Sample Data Collection Forms

4. Copy of Proposal Submitted to Stuart Foundations.
   Funding notice received in April 1988.

5. Other

APPENDIX 1

Agency Description

The Children's Bureau of Los Angeles (CBLA) was founded in 1904 as a private, nonprofit, nonsectarian multiservice organization overseen by a Board of Directors. CBLA was established to promote the welfare of children and to prevent the abuse and neglect of children. Through the organization's 84 year history, its commitment to the major goals of the founders has remained the same: "To institute programs and policies . . . which would serve the interests of families in the Los Angeles area." The agency's philosophy is that children can grow to be constructive adults when given the opportunity to be nurtured in caring families, their own or others. The agency has continued to reflect that philosophy in the development of its comprehensive program which provides services ranging from early prevention with high-risk families to intensive therapy with children who have been the victims of child abuse.

Over the years, Children's Bureau has become recognized for its leadership in pioneering child abuse prevention and for its treatment services to troubled families with children 12 years of age and under. The target area is Los Angeles County and services are provided without regard to race, creed or national origin.

Included in the continuum of services currently being provided by the Children's Bureau is the therapeutic group home program serving children between the ages of four and twelve whose early experiences in family life have frequently left them physically bruised and emotionally scarred. Children's Bureau's four group homes are operated in a community-based family model setting supported by social work, psychological and psychiatric services. Two homes are located in Culver City and two homes are located in Van Nuys.

As a licensed Foster Family Agency, Children's Bureau also features an extensive foster care program designed to provide specialized professional support to those carefully screened, certified and trained families in the community who are able to open their homes to children who need to be placed away from their natural families. Children's Bureau social workers are available on a 24-hour basis to participating foster families who are located throughout Los Angeles County.

For children five years of age and younger, Children's Bureau maintains a 24-hour residential shelter care facility, the Family Crisis Center, located in North Hollywood. Constructed on the community-based family model design, the Family Crisis Center provides a safe, homelike environment for very young children who have been removed from their families because of instances of alleged abuse or neglect. While the children are with us at the Family Crisis Center they are evaluated to determine their developmental status, health care needs and other underlying problems. Developmental remediation is provided where indicated while the children are at the center.

In 1983, the considerable experience accumulated throughout the years of providing treatment services provided the springboard for the development of a new program. This program was initially conceived to bring child abuse prevention services directly into the homes of "high-risk" families. Teams of diversely trained Family Response Workers (FRW) respond to calls from a variety of referral services, including the Department of Children's Services (DCS), the Courts, the police, local hospitals, other social service agencies and former clients. This program characterizes our belief that the most effective treatment comes through prevention and early intervention.

As this program, known as the Family Connection Project (FCP) has evolved, it has been expanded from two original program sites in the San Gabriel Valley (El Monte/Sup. Dist. I) and the San Fernando Valley (Van Nuys/Sup. Dist. V) to five sites including the Centinela Valley (Inglewood/Sup. Dist. II), the Antelope Valley (Lancaster/ Sup. Dist. V) and Central Los Angeles (Sup. Dist. III). Prevention services offered by the Family Connection Project are tailored to be responsive to each of the communities served and include in-home and in-office counseling and crisis intervention; bilingual parenting education (both in-home individualized parenting education and classroom parenting); and a broad range of family support services that include providing linkages with appropriate community services and demonstrating basic family survival skills. The Family Connection Project served approximately 2,400 clients in calendar year 1987.

APPENDIX 2

The following are letters of support for Children's Bureau of Los Angeles for the Request For Proposal submitted to Los Angeles County in March 1988.

INFO LINE
INFORMATION AND REFERRAL FEDERATION OF LOS ANGELES COUNTY
3035 Tyler Avenue, El Monte, California 91731 • (818) 350-1841

March 4, 1988

Ms. Judy Nelson
Children's Bureau of Los Angeles
2824 Hyans St.
Los Angeles, CA 90026

Dear Judy:

I am writing in support of your proposal for continuation of funding for the Family Connection Project under AB 1733-2994. As I have stated in the past, we have a first hand appreciation of the needs of high risk families in need of child abuse prevention services.

Many such families need preventative intervention but are unable to make their way through the established referral process. They need some degree of on-going support in making the needed connections to services. Without it, their problems remain untreated and the likelihood of abuse occuring is great.

The multi-faceted child abuse prevention program which you have been operating for the past five years in the San Fernando and San Gabriel Valleys has provided a badly needed response. By working to prevent child abuse through parenting education, counseling and in-home support services with both English and Spanish speaking staff, the Family Connection Project is making a significant contribution to the service community. In this project, you have demonstrated the responsiveness and professionalism which are the Children's Bureau's hallmark.

We strongly support the program and hope that it is continued.

Sincerely,

Linda Lewis
Executive Director

LL:mav

PHMC

Palmdale Hospital Medical Center

March 9, 1988

Family Connection Project
44850 Cedar
Lancaster, CA 93534

To Whom It May Concern:

I am writing this letter in support of the Family Connection Project. Working as I do for a County Facility, and dealing with Chemical Dependency, I have on several occasions had need of Services for the families especially the children involved in this Disease. Many of my clients lack parenting skills and many of the children bare the scars of this disease. Because many of the families I see are of low or no income, the Family Connection being a Community based service has been a Godsend. Their In-Home Services, Parent Support and Training that includes Child Care Services have made it possible for those I referred to get help where they might otherwise not have.

I am encouraged and I support and salute you for this much needed Service.

Sincerely,

Suzanne O'Leno
Chemical Dependency Counselor

1212 East Avenue S • Palmdale, California 93550 • (805) 273-2211

NORTH LOS ANGELES COUNTY REGIONAL CENTER
A NON-PROFIT CORPORATION SERVING PERSONS WITH SPECIAL DEVELOPMENTAL NEEDS

☐ MAIN HEADQUARTERS
14550 Lanark Street
Panorama City, CA 91402
(818) 997-[illegible]

☒ SATELLITE OFFICE
348 East Avenue K-4
Lancaster, CA 93535
(805) 945-6761

☐ SATELLITE OFFICE
405 North Maclay St
San Fernando, CA 91340
(818) 365-[illegible]

☐ SATELLITE OFFICE
24880 North Apple St
Newhall, CA 91321
(805) 255-[illegible]

March 7, 1988

Family Connection Project
Children's Bureau of
Los Angeles
44850 Cedar Avenue
Lancaster, Ca. 93534

To Whom It May Concern:

This letter is to provide the Antelope Valley Satellite office of North Los Angeles County Regional Center's unqualified support for the excellent working relationship and resource staff for our clients and the families of our clients, the developmentally disabled of Antelope Valley.

The population growth over the past several years has stretched all of us to the breaking point, however, the willingness and cheerful cooperation of your staff in Antelope Valley to coordinate planning and implementation of efforts is noteworthy. Obviously, our greatest natural resource is our children, thus families. The needs of this agency alone could keep double your staff busy around the clock, to say nothing of the global needs of families throughout the valley.

We add our unqualified support to their efforts to expand the services they are already providing in an area where there exists a tremendous gap between the needy and existing resources.

Thank you for the chance to input.

Sincerely,

Carl Breckenridge, M.S.
Supervising Counselor

CB:bjm

Foundation for Early Childhood Education, Inc.
A NON-PROFIT CORPORATION

HEAD START/STATE PRE-SCHOOL PROJECT
CHILD DEVELOPMENT CENTERS
DEMONSTRATION PROJECTS

March 18, 1988

rector
Martha Rinaldo
embers of the Board
esident Emeritus
Sarah G. Tavlor
esident
Evelyn Gratts
ce President
Jackie Roberto
cretary
Sylvia Gonzales
easurer
Pat Fukushima Cager

Lena Britt
Carolina Flores
Nodie Goodson
Barbara Mendez
Marjorie Morris
Yvonne Nishio
La Vada Reese
Rosemary Sims

Children's Bureau of Los Angeles
2824 Hyans Street
Los Angeles, CA 90026

TO WHOM IT MAY CONCERN:

Our agency is very pleased with the services you have provided to parents in our program, and we would like to offer our support of your proposal to obtain funding to continue your child abuse intervention and prevention services under AB 1733 and AB 2994. As you know, we have referred several of our at-risk families to your agency, and your intervention has made a big difference in their lives. Your staff have provided very necessary support to these parents, in addition to training them in the use of more appropriate disciplinary measures and limit-setting skills. We feel that working with the families in their homes helps to establish a more immediate rapport between family members and your staff since family members remain in surroundings comfortable to them. In addition, many of our families would find it very difficult obtaining transportation to and from a clinic that might be miles from their home. Furthermore, we have many Hispanic families in our program, and your bilingual services are invaluable to us.

I recommend with much enthusiasm that your agency receive continued AB1733-2994 support for the Family Connection Project. Your in-home child abuse intervention and prevention services are greatly needed in our community, and they are greatly valued. We have seen improvement in our families' ability to parent constructively and communicate more fully their needs and wishes. Since such skills are essential in maintaining healthy family functioning, your work must be allowed to continue uninterrupted.

Sincerely,

Tammy-Solko, M.A.
Social Services Coordinator

BEST COPY AVAILABLE

Santa Monica
Hospital
Medical Center

1225 Fifteenth Street
Santa Monica, CA 90404
(213) 319-4000

CHARLES E. PAYTON, M.D.
Director, Family Practice Program

March 16, 1988

To Whom It May Concern:

I would like to strongly recommend continued support of AB1733-2994 for the Family Connection Project, a child abuse prevention program which provides services in the home setting.

As a clinical social worker who teaches resident physicians and provides services for patients it is useful to have a program of this type which targets prevention. The model of prevention is one with which the physicians are familiar. The Family Connection Project is of the utmost importance in providing the kinds of services which have the opportunity to contribute to a solution for families in stress and in danger of hurting their children.

As a society it is imperative that we fully fund programs such as the Family Connection Project, which provide preventive services for populations at risk for committing the heinous acts of child abuse.

Deborah Silverman-Poulson, LCSW
Deborah Silverman-Poulson, LCSW

DSP:SMN

COUNTY OF LOS ANGELES
DEPARTMENT OF CHILDREN'S SERVICES

1125 West Sixth Street - Los Angeles, California 90017
(213) 482-2767

OBERT L. CHAFFEE
Director

BOARD OF SUPERVISORS
PETER F. SCHABARUM
KENNETH HAHN
EDMUND D. EDELMAN
DEANE DANA
MICHAEL D. ANTONOVICH

February 25, 1988

Children's Bureau of Los Angeles
3030 Tyler Avenue
El Monte, California 91731

To whom it may concern:

As the office administrator at Children's Services office at 3410 La Madera in El Monte, through my Children's Services Workers, I am well aware of the utilization of the services that the Family Connections Project provides to our clients.

I am writing in support of your proposal for funding to continue your child abuse intervention and prevention services under AB1733 and AB2994. The quality of your in-home services, parent support and training and child care services is viewed positively by referral services and clients.

The Family Connection Project has been particularly effective because it is community based and has reached the ethnically and culturally diverse population by employing bilingual and bicultural staff.

These services have really made a difference to families who are at risk. The services are helping families improve their relationships and stay together.

Yours very truly,

Chester Millsap

Chester Millsap
Deputy Children's Services Administrator

CM:ds

RE: Family Connection Project
Children's Bureau of Los Angeles

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES
313 NORTH FIGUEROA STREET • LOS ANGELES, CALIFORNIA 90012 • (213) 974-

HEALTH CENTER OPERATIONS EAST AREA
WHITTIER HEALTH DISTRICT

February 29, 1988

To Whom It May Concern:

We at Los Angeles County Health Services regard the Family Connection Program funded by AB1733-2994 as outstanding. Our community depends on their in-home counseling and the parent support training.

Family Connection has effectively reached out into our community and provided bilingual staff. It has made a difference to our high risk families in helping give support and improve their survival skills and to relate better with each other.

Please continue their funding under AB1733 and AB2994.

Sincerely yours,

Joyce LeCoq

Joyce LeCoq, R.N.

Re: Family Connection Project
Children's Bureau of Los Angeles

PICO RIVERA HEALTH CENTER - 6336 S. Passons Blvd., Pico Rivera CA 9
Telephone 213/949-661

EL MONTE CITY SCHOOL DISTRIC
3540 North Lexington Avenue, • El Monte, California 91731 (818) 575-2382

F EDUCATION

EY MANTE
President

EN HAKE
e President

RT PEVIANI
Clerk

AMEROTA
Member

D REED
Member

ISTRATION

ISHNO, Ed.D.
Superintendent

ERMAN, Ed.D.
Assistant
erintendent
nstruction

E ROEBUCK
Assistant
erintendent
Personnel

BUCHANAN
Assistant
erintendent
Business

March 2nd, 1988

To Whom it may concern,

I am writing in support of your proposal for funding to continue your child abuse intervention and prevention services under AB1733 and AB2994. The services offered by this program have helped countless children and parents in our school district. Without the services of the Family Connection Project there would be many needs unmet and as a result continued child abuse and neglect. The outreach and in-home services provided by the AB1733-2994 funded child abuse program of the Family Connection Project is desperately needed in our area and the bi-lingual capacities are invaluable.

We at the school district only wish that there were more programs available to us like this one. If the thousands of people helped by this program could only unite to include their support I am sure that there would be no question as to the desperate need to continue this service and its funding.

Thank you for the opportunity to give support to this great service.

Sincerely,

Rebecca M Shultz

Rebecca M. Shultz
School Counselor
El Monte City School District

FAIR HOUSING COUNCIL of
san gabriel valley

PASADENA OFFICE
North Fair Oaks Avenue, Pasadena, CA 91103
(818) 791-0211

EL MONTE OFFICE
3017 North Tyler Avenue, El Monte, CA 917
(818) 579-6868

he communities of
Park
Springs
Monte
Pasadena
Valley
Heights
Oak Islands
Islands
sadena
an Gabriel
a Mesa
Whittier
San Gabriel
Monrovia Islands
Puente Valley
Whittier-L Nieto
Narrows

February 22, 1988

TO WHOM IT MAY CONCERN:

The fair Housing Council of San Gabriel Valley is writing in support of the proposal for funding to continue Family Connection Project child abuse intervention and prevention services under AB1733 and AB2994. The quality of Family Connection in-home services, parent support and training, and child care services are outstanding and an essential service for the community.

The Family Connection Project has enhanced the quality of life for the clients they have served and the clients we have continually referred to them for assistance. The bilingual and bicultural staff which has been employed by Family Connection Project has been a great asset to the services they provide.

These services have really made a difference to the families in improving their relationships and have given a path for the families to remain together. The Community really depends on these in-home counseling, parenting support training and child care services.

Sincerely,

Brigitte Wamsher
Program Coordinator

BW:mvc

APPENDIX 3

The following are samples of data collection forms used by Children's Bureau of Los Angeles.

PSYCHOSOCIAL SUMMARY

SUMMARY
CASE # ____________________
DATE OPENED ________________
DATE CLOSED ________________

WORKER ____________________
OFFICE ____________________

NOTE: First assessment line indicates initial assessment. Second line indicates termination assessment.

ISSUES	STRENGTHS	CONCERNS/PROBLEMS
I. Environment A. Outside Home 1 2 3 4 5 1 2 3 4 5		
B. Outside Home 1 2 3 4 5 1 2 3 4 5		
C. Social 1 2 3 4 5 1 2 3 4 5		
D. Financial 1 2 3 4 5 1 2 3 4 5		
II. Caretaker I A. History 1 2 3 4 5 1 2 3 4 5		
B. Personal Characteristics 1 2 3 4 5 1 2 3 4 5		
C. Parenting Skills 1 2 3 4 5 1 2 3 4 5		
III. Caretaker II A. History 1 2 3 4 5 1 2 3 4 5		
B. Personal Characteristics 1 2 3 4 5 1 2 3 4 5		
C. Parenting Skills 1 2 3 4 5 1 2 3 4 5		

SUMMARY

III. Children

Children In Home ________ Children Out of Home ________

A. Child Development	Questionable		Areas of Concern
Child(rens) Names	Yes	No	
1.			
2.			
3.			
4.			
5.			
6.			

B. Problem Check List

Child 1: ________ Problem(s) ________
Strengths: ________

Child 2: ________ Problem(s): ________
Strengths: ________

Child 3: ________ Problem(s): ________
Strengths: ________

Child 4: ________ Problem(s): ________
Strengths: ________

Child 5: ________ Problem(s): ________
Strengths: ________

Child 6: ________ Problem(s): ________
Strengths: ________

TREATMENT PLAN

CASE NUMBER ____________________

WORKER ________________________

OFFICE ________________________

PRIMARY GOALS:

1. ____

2. ____

3. ____

METHODS:

GOAL 1. ____

GOAL 2. ____

GOAL 3. ____

TERMINATION REVIEW

OFFICE ______________

CASE #: ______________

WORKER ______________

DATE OPENED: ______________

NUMBER OF CONTACTS:

DATE CLOSED: ______________

WITH CLIENT: ______________

REASON FOR TERMINATION:

ANCILLARY: ______________

_____ Completed

_____ Dropped out

_____ Moved out of area

_____ Other: (Specify)

_____ Refused service

____

OUTCOME ON GOALS:

	ASSESSMENT RATINGS	
	1st	2nd
Goal 1 ______________	_____	_____
Goal 2 ______________	_____	_____
Goal 3 ______________	_____	_____

WORKER'S SUMMARY OF PROGRESS:

DISPOSITION/REFERRAL:

Was client referred to another agency for additional services? yes/no

Did child(ren) go into any type of out of home placement? yes/no
If yes, please specify ______________

Comments: ______________

____

CHILDREN'S BUREAU OF LOS ANGELES
FAMILY COUNSELING PROGRAM

PROGRAM SATISFACTION QUESTIONNAIRE DATE: ____________

We are eager to know whether the services you received from our program have been helpful or not. Your opinions are important to us. Please answer all questions even if you have to give your best guess. If you have received services from this program before this, please tell us only about your most recent period of service. It is not necessary to sign your name. Please complete, and put in accompanying envelope and seal.

ALL ANSWERS ARE CONFIDENTIAL

Please circle the letter of the best answer:

1. Regarding what brought you to our program, are you getting what you wanted to get?
   A. Yes, completely
   B. For the most part
   C. Somewhat
   D. Made a start
   E. Made no progress
   F. Don't know
   G. Changed my idea of what I wanted

2. In general, how do you feel about the services you receive?
   A. Very satisfied
   B. Satisfied
   C. Somewhat dissatisfied
   D. Very dissatisfied
   E. No particular feelings one way or the other

3. Would you recommend these
   A. Yes
   B. No
   C. I don't know

4. Considering all the reasons that brought you here, has this program helped your situation?
   A. Things are much better
   B. Things are somewhat better
   C. Things are unchanged
   D. Things are somewhat worse
   E. Things are much worse
   F. Things are better in some but worse in others

5. Which services provided by our agency were the most helpful to you?
   A. Individual/Family counseling
   B. Parent Support Groups
   C. Child care during groups
   D. Transportation
   E. Help getting other community services
   F. Respite care
   G. Provision of in-home services
   H. Other

6. Are there any changes you would make regarding services offered by this program? Yes __ No __ If yes, please comment:

Please make sure you have answered all questions. Thank you very much for your help.

3/87
[illegible]

FAMILY CONNECTION PROJECT

MANAGEMENT LOG - QUALITY CONTROL

1. Intake and Assessment ____
2. Consents (filled-out and signed) ____
3. Pycho-social assessment ____
4. Summary treatment case plan ____
5. Day care provider and/or school contacted ____
6. Services provided
   A. In-home counseling: Adult ____
   Child ____
   Family ____
   B. Respite care: ____
7. Parent training group
   A. Attendence log: ____
   B. Parent training education: ____
8. Termination Review ____
   A. Maintenance form ____
9. Program Satisfaction questionnaire ____

3/10/88
FCPQUALI

MONTH: ____________

			[illegible]												SERVICES			
			INDIVIDUAL		FAMILY				INDIVIDUAL		FAMILY							
IENT NAME:	FOLLOW-UP	ON-GOING CASE REFERRALS	ADULT	CHILD/PLAY	PARENTS ONLY	PARENT(S) AND KIDS	SIBLINGS/PLAY	GROUP	ADULT	CHILD/PLAY	PARENTS ONLY	PARENT(S) AND KIDS	SIBLINGS/PLAY	IN-HOME PARENT EDUCATION SERVICE	TRANSPORTATION	CONCRETE SERVICES	ADVOCACY	CHILD CARE DURING COUNSELING

WORKER: ____________

PRESENTATIONS:

DATE	# OF PEOPLE

ADVOCACY:

- *Letter
- *Court Appearances
- *Phone Calls w/other Professionals RE: Client

CONCRETE SERVICES:

- * Food
- * Clothing
- * Furniture

APPENDIX 4

CHILDREN'S BUREAU OF LOS ANGELES
IN-HOME PREVENTION PROJECT PROPOSAL

To The
ELBRIDGE STUART FOUNDATION

The Problem

Based on the growing numbers of increasingly disturbed children coming into out of home care, the staff of Children's Bureau of Los Angeles is convinced that some of the children could have remained with their families and avoided family disruption had there been prevention oriented intervention earlier in their lives. Such early intervention, if successful, could not only have prevented severe, often permanent damage to children but have reduced the expensive costs of out of home treatment.

Evidence is mounting that without such intervention, many more children will need care in the future with fewer resources available to serve them. In addition, the costs of intensive treatment are skyrocketing and policy makers appear to be increasingly unwilling to fund full costs of quality care.

The immediate problem, however, is not so much that more prevention and early intervention services are needed (although that seems clearly indicated to service providers), but rather that the child welfare profession is unable to prove that any prevention services really make a difference, other than through anecdotal, highly subjective data. Without some kind of evidence of effectiveness, public policy makers, who must be reelected every few years, cannot or will not invest in efforts where results are pure speculation by social service professionals.

At a time when other social needs are becoming more pressing, more costly, and more visible (i.e., aids, drug abuse, the elderly), competition for limited resources is and will continue to intensify dramatically.

It is clear that hard data is needed to determine 1) which families might benefit from earlier intervention, 2) which interventions have the greatest impact and what the cost/benefit of such interventions would be. Children's Bureau of Los Angeles has initiated some pioneering steps designed to address this data gap. We are seeking funding to formally test the hypothesis that high risk families can be identified and can learn adaptive behaviors which can contribute to a healthier environment in which children can grow.

General Program Goals

Recognizing that all or most of the clients served in this project will be multi-problem, often crisis prone families, and that few are likely to be "model" citizens, the family which we can expect to best serve would be one which:

1) could identify warning signals of individual and family stress;

2) has learned some alternatives to violence when under stress;

3) has acquired knowledge of the location and nature of basic social services and will use those services when appropriate; and

4) has an understanding of the child's basic needs.

A fifth objective which is less basic but also significant would be to determine those families who have substantial positive involvement in the child's life (i.e., becoming the child's advocate in school; joint library visits; enrolling in after school activity; less verbal criticism; some positive reinforcement, etc.)

Working with these families would serve to impact significantly on the quality of life for them, and the data generated there would serve to address the ultimate goal of making a major impact on public policy in this country.

Working together with two sister agencies to evaluate the effectiveness of a spectrum of service models in relation to a specific client population would greatly enhance our collective service delivery capability. In addition, it would allow us to exercise the traditional, vital and all too often fading role of the private child welfare provider; that of demonstrating to public sector policy makers a more effective, less bureaucratic and less expensive means of delivering quality human services.

The Children's Bureau Program

Throughout its history, Children's Bureau has consistently attempted to find ways to intervene earlier in a child's life and to prevent family breakdown whenever possible. In order to demonstrate its commitment to prevention and to test some ideas gained through experience with families, in 1983 the agency launched its Family Connection Project. This project provides in-home and parenting education services in five locations in Los Angeles County with two different funding sources, AB 1733 and AB 2994. (United Way and others concerned with public policy issues affecting families have also supported this project to a limited extent.)

The philosophy underlying the Family Connection Project was based in large part on the agency's experience with providing emergency shelter in its Family Crisis Center to mothers and their children at risk of abuse. In that program we learned first hand of the benefits of a team approach, the extremely positive effect of modelling behavior and relationships under home-like conditions and the major impact of teaching simple but basic parenting and home management skills through demonstration and example.

The Inglewood neighborhood was selected as the site for this project for a variety of reasons. First, the agency has a strong commitment to serving those populations in greatest need. This primarily black but changing area has a large number of families experiencing multiple problems including poverty, single parenthood, delinquency, teenage pregnancy and high rates of child abuse. In addition, the Inglewood community is dramatically underserved by both public and private social service agencies. Because of the agency's commitment to underserved areas, we have maintained a small outpost in Inglewood for some time which includes one Family Connection team.

We are proposing a program in the Inglewood area, tailored for the needs of that community, in which extensive in-home and parenting education services would be provided to families at risk of child abuse, child neglect and/or family disruption. The program would include a major evaluation component which would involve collaboration with other agencies. While the concept of participatory evaluation is new to this agency and for the most part, to the child welfare field, Children's Bureau would welcome the opportunity to share its knowledge, its questions and its data with respected colleagues in the interest of answering the key questions identified.

The Clients

The clients who will be served by this project will be families with infants and children up to age twelve who are at risk of child abuse, child neglect and/or family disruption. In an attempt to reach clients who have not yet established a pattern of abuse and neglect (or inflicted permanent damage on their children) the research effort will be directed at families whose children have not been removed from their parents for longer than three days.

A portion of the clients will be referrals from the Los Angeles County Department of Children's Services (DCS). A primary target group for referrals will be those families rejected for service as not meeting the definitions of abuse and neglect as outlined by California Senate Bill 243. The targeting of this group of clients is based on the assumption that such families, without intervention, are highly likely to become clients of the protective service system. The remainder of the referrals will be solicited from schools, health facilities and from other clients.

Staffing

Overall direction for the proposed project will be provided by the agency's Executive Director, Judith Nelson. Ms. Nelson, who holds a Juris Doctor degree from the University of Kansas and a master's degree in social work from Virginia Commonwealth University, has been Executive Director of the Children's Bureau for seven years. She is currently also serving as the President of the California Association of Services for Children.

The core direct in-home service staff of the Inglewood project will include two two-person teams. One member of each team will have a master's degree in the behavioral sciences, preferably with experience in working with families. The junior member of the team will have a bachelor's degree and related experience. Backing up the teams and assisting in the provision of support services will be a secretary/case aide. This position would require a high school diploma or equivalent, with some clerical experience and an ability to work with families.

Program supervision will be provided by a Program Director (1/2 time) who would need to have a minimum of a master's level degree in the behavioral sciences with demonstrated experience in grant and program management. Preference for culturally sensitive staff would apply for all project positions, particularly for direct service staff.

Program specific research consultation would be provided by researchers selected for their unique blend of expertise in the areas of social work research and children and family issues.

Additionally, the project would have the benefit of drawing on the consultation of a skilled administrative team combining extensive experience in program design, nonprofit multi-program accounting, and the identification and recruitment of talented in-home family support workers.

Nature of Services

Services will be provided primarily in the homes of clients. In addition, parenting classes will be offered in agency offices or in borrowed space located in client neighborhoods, such as churches, etc.

The average length of service will be four months. In home services will be provided during regular office hours while parenting classes will be offered day or evening according to client need. Services in client homes will ordinarily be provided once a week for one to two hours.

Initial assessment provided would include a team diagnosis, a determination of the agency's ability to respond and a contract with the family regarding desired outcome. Intervention services offered would include counseling, crisis intervention, home and resource management such as child safety-proofing; limited employment assistance; parenting skills and anger management with special emphasis on nonviolent and positive discipline, communication and relationship modelling. Intervention with and on behalf of the family would be provided where appropriate with other systems including schools, courts and medical facilities. In addition, very limited and temporary assistance, where no other resources are available, could be provided for emergency food, diapers or other small items. A variety of other ancillary services will be provided including parenting classes, information and referrals, respite care for a limited number of appropriate children, and community education.

All initial visits to client homes will be made by a team. Subsequent visits will usually be made by one worker unless safety or other factors dictate otherwise.

Projected Client Statistics

Once fully trained, each team member would be expected to handle twelve cases (families) at one time, or seventy-two families in the designated research period of twenty-four months. Two teams would work with approximately 288 families in a two year period. (Assuming only a few families in the start up period, the last six months of the project would add about 72 families to the number served.)

(Because one of the many unknowns in these kinds of services is how long the service needs to take, it would be possible for one team to see its families for four months and the other for a six month period in order to compare results. This would, of course, decrease the total number of families served but could produce valuable data.)

Conclusion

Support from the Stuart Foundation for this proposed project would allow the Children's Bureau to reach out to an extremely high need population not currently being served. In addition to the direct prevention impact which would be experienced by these at-risk, underserved clients, we are vitally interested in the chance to work jointly with the respected collegial agencies and with the Foundation's own evaluation team. As part of a larger community team, we see a truly unique opportunity to build a body of data providing the insight to significantly advance the quality of prevention services and the power to alter local, state and national child welfare public policy.

1/7/88

LOREN'S BUREAU OF LOS ANGELES THREE YEAR BUDGET

EXPENSES	1ST YEAR	2ND YEAR	3RD YEAR	TOTAL 3YRS
SALARIES (INCLUDES BENEFITS)				
PROGRAM DIRECTOR 50%	$24,000	$25,200	$26,460	$75,660
2 TEAMS (2 PERSONS PER TEAM)	$90,774	$119,142	$125,098	$335,014
SEC/CASE AIDE	$16,875	$22,148	$23,256	$62,279
TOTAL SALARIES................	$131,649	$166,490	$174,814	$472,953
OPERATING EXPENSES				
RENT	$12,000	$12,000	$12,000	$36,000
UTILITIES	$2,050	$2,153	$2,260	$6,463
TELEPHONE	$1,500	$1,575	$1,654	$4,729
SUPPLIES	$1,800	$1,890	$1,985	$5,675
MAINTENANCE	$1,200	$1,260	$1,323	$3,783
TRANSPORTATION	$1,800	$1,890	$1,985	$5,675
TOTAL OPERATING EXPENSES......	$20,350	$20,768	$21,206	$62,323
RESEARCH & TRAINING...........	$16,000	$19,000	$19,000	$54,000
INDIRECT COST (12%)...........	$20,160	$24,751	$25,802	$70,713
TOTAL PROGRAM COSTS..........	$188,159	$231,009	$240,822	$659,990

APPENDIX 5

Other

Assisting us, in addition to Dr. Jacquelyn Mcroskey, are two very talented University of Southern California Assistant Professors, Robert Nishimoto and Karen Subramanian. This is truly a team effort and much has been learned in the process.

The other vital part of the research team has been the members of the Family Connection Project, coordinated by Linda Waters under the supervision of CBLA Program Director Judy Sweeney.

Financial guidance and support has been expertly provided by Richard Klein, Vice President of Administration.

Finally, none of the services would have been provided without the ongoing support and hard work by the agency's Board of Directors.

Chairman **Miller**. Thank you. Thank you very much. Doctor Ferkich.

STATEMENT OF EUGENE R. FERKICH, COORDINATOR OF STUDENT SERVICES, LOS ANGELES, CA

Mr. **Ferkich**. Congressman Miller. Ms. Mallis and I are representatives from the Los Angeles School District and the Los Angeles County Interagency Planning Task Force for services to infants, toddlers and their families. The Task Force is dedicated to developing a proposed county-wide plan for services to disabled infants and at-risk infants in the family and we are here to give you an overview of some of the issues that are being raised on this Committee. I divided my presentation into three parts and the first part was critical complicating variables and I think you have heard all of those this morning so I will just move onto the issues that we are talking about in terms of programmatic components of our plan. One of the concerns, of course, is geographic availability of services and with a County as large as this one, it is a tremendous problem to make a coherent core of services available to all families and so that is one of the issues we need to deal with.

Another is the interagency coordination that you heard so much about this morning. It is a definite problem without a doubt and we are working on it and we are talking. Another area of concern is eligibility. Just exactly who is eligible for services under this law. I do not know if I mentioned it, it is 99–457 funding.

We do need to collaborate in order to operate more cost effectively and we also need to identify new sources of funds because the problems, as you know, are increasing. We are looking at means from which to collect data and maintain a data base that would include information about the children as well as available resources for services. Also, we need some quality assurances built into the plan. Some kind of standardization in terms of qualifications for personnel as well as programs and also a monitoring track for programs. There are many, many anticipated outcomes that I am sure exist. However, we have listed only four and maybe you can help us with adding to our list. But, we do plan to address services for parents so that ultimately, they would be more effective in serving their children, working with their children and parenting and also to become the primary advocate for the child. We also feel that a product of this effort should be a coherent system of services available County-wide for every family that has need and easy access and finally, we are looking toward the development of a uniformed method of collecting data and exchanging data between agencies where it is appropriate.

We have been in the infant service business for awhile. We do have infant programs for the blind and the deaf as well. I thought I would ask Ms. Mallis to speak about the deaf.

Mary Ann.

Ms. **Mallis**. Thank you. Good afternoon.

Chairman **Miller**. Good afternoon.

STATEMENT OF MARY ANN MALLIS, COORDINATOR, EARLY INTERVENTION PROGRAM, SPECIAL EDUCATION DIVISION, LOS ANGELES UNIFIED SCHOOL DISTRICT; LOS ANGELES COUNTY INTERAGENCY TASK FORCE FOR INFANTS AND FAMILIES

Ms. **Mallis**. Intervention services do work and we have had that opportunity to see them and I would just like to take a few minutes of your time to tell you all about it.

We have heard crises after crises today of what is happening and unfortunately it took a crises for us in education to see that is we did not do something, when in the 60's we had the German measles epidemic and we had the large number of deaf children that were born, staff members realized right away that we could not wait until they were three years old because that was what the State of California had allocated to begin serving these children.

So, in 1973, an infant program began with working with the children. It was on the basis of—on a one-to-one. We had one teacher for 8 children. We still have that same ratio today. These teachers went into the homes. It was the—the family was basically the whole part of this program. We could not just serve the baby. We did not want anyone just bringing the baby into a school and leaving it there. The teachers would go into the homes, would work within the home structure on what they could help the parent in creating a language situation. We were very limited at the beginning but it quickly grew and we recognized that by having the language based service, assisted the parents to recognize that their children, yes, indeed, were deaf but they may not have a language that would be considered the same as everyone else. This was difficult for them to accept and this was a challenge and they had to become the advocate.

I think this new law, that is what the whole thing is, we have to help that parent become an advocate for their children if we are going to create positive environment. We do not have the German measles epidemic today but we have heard many, many other crises that are going on and we still have the deaf population. We have not been able to erase that.

New technology has enabled us to recognize that children have hearing losses sooner but that just helps us to know that our infant program has—is working to its better advantage. We have been able to track the children and I would like to tell you that we do now know that after working with them as infants, and getting to them sooner, when they are three years old, they can be in a more positive environment and by the time they are of school age, which would be kindergarten, we have seen a mainstream.

A few years after the deaf program, we have an infant program that began for the blind. This, too, has been successful and we have been tracking it. We have what we call a "center based program" now and just to let you know, we are bringing the mothers and the babies into a school and helping them with multi-disciplinary services.

We know that this new legislation is on the right track. It is a family component that we have to work with. We have heard them taken out of their homes, we have heard them done in foster homes, we have heard them—but our teachers recognize that when they go in the home and they can help with the infants as early as possible, that it has been successful.

[Prepared statement of Eugene R. Ferkich and Mary Ann Mallis follows:]

PREPARED STATEMENT OF MARY ANN MALLIS, M.A., COORDINATOR, EARLY INTERVENTION INFANT AND TODDLER PROGRAM, DIVISION OF SPECIAL EDUCATION AND EUGENE R. FERKICH, ED.D, COORDINATOR, STUDENT SERVICES DIVISION OF SPECIAL EDUCATION

Introduction

Public Law 99-457 provides for the planning and development of early intervention programs for infants, toddlers and their families. The primary objective of this law is to establish a new state grant program for handicapped infants and toddlers, ages birth through two years, for the purpose of providing early intervention services for all eligible children as defined by the legislation. This program appears as a new Part H of the existing Education of the Handicapped Act.

The legislation defines the eligible population as all children from birth through two years of age who are developmentally delayed (criteria to be determined by each state), or with conditions that typically result in delay, or (at state discretion) who are at risk of substantial developmental delay.

Federal funds under this grant program are to be used for the planning, development and implementation of a statewide system for the provision of early intervention services. Currently, Los Angeles County has an Interagency Planning Task Force which is dedicated to the development of a proposed countywide plan for services to infants, toddlers and their families. The following report reflects some of the issues being discussed by the task force during the preliminary planning phase.

I. VARIABLES THAT IMPACT PLANNING

A. Size

Los Angeles County is 4083.21 square miles in size with 85 cities and a population of 8,208,866 as of January 1987. The county includes 82 school districts with a current population of 1,300,000 students.

One of the cities within Los Angeles County is Los Angeles. This city has 470 square miles and a population of 3,214,000. The Los Angeles Unified School District includes 822 schools and centers with a K-12 enrollment of 592,273 students.

B. Composition of the Population

Los Angeles County's population is truly diverse in that it includes people from a myriad of racial and ethnic backgrounds. Within the Los Angeles Unified School District alone there are between 80-90 different languages spoken in the homes of the students.

C. Urban Issues

The problems that affect the Los Angeles County urban area are essentially the same as those that exist in all other major population centers in this country, except that the area is a main U.S. immigration center. Among the distressing factors that impact the infant population are poverty, crime, drug abuse and child abuse.

D. Existing Service Agencies

Services are currently being provided to infants and their families by a complex network of service delivery agencies, some public and some private. Among the programs and services available are the following:

1. **Department of Health Services**

    a. The California Children's Services Program provides all services necessary to meet the health care needs of physically handicapped children who are found eligible under this agency's criteria.

b. The Child Health and Disability Prevention Program offers periodic health examinations and referral for diagnosis and treatment.

c. The Maternal and Child Health Branch contracts with community-based agencies to provide preventative and early intervention services for infants and their families enrolled in the High Risk Infant Follow-up Project.

2. **Department of Education**

a. The Office of Child Development provides a full range of developmentally appropriate child care services for children from birth while parents are at work, in training, seeking employment, incapacitated or in need of respite care.

b. The Office of Special Education provides early intervention programs for individuals with exceptional needs who require intensive special education services. Examples of such services being offered in the Los Angeles Unified School District are its programs for deaf and blind infants and their families.

3. **Department of Developmental Services**

a. The Department of Developmental Services, through its' contractual agreements with Regional Centers, provides a full range of services to persons with development disabilities and infants considered to be at high-risk of becoming developmentally disabled. The regional centers may purchase services from any individual or agency that would meet their client's needs.

II. ISSUES TO BE ADDRESSED IN THE PLAN

A. Availability: Geographical Availability of All Relevant Services

A continuum of services which include a variety of options and levels of services must be available throughout the county.

A full range of services available to infants and families would include medical, psycho-social and developmental services. The continuum should extend from early identification, evaluation and assessment to complete early intervention programs.

Early intervention programs share a common concern for the needs of infants. Program models may differ in meeting the unique needs of a selected population or type of service. However, all early intervention programs have some commonalities: they provide services to both the child and family by a team of experts, including health, education and child development specialists based on the child's strengths and developmental level.

Services for infants have developed gradually in California over the last several years. The Department of Health Services, the Department of Education and the Department of Developmental Services all have responsibility to provide services to infants and families. As a result, programs for infants may be found in hospitals, public and private schools, private nonprofit community agencies, child care settings and in parent sponsored organizations. These programs have developed using a variety of eligibility criteria, different funding methods and certification requirements.

The availability of services varies markedly from community to community. In some areas there are very few or no services available for infants and families while other communities in Los Angeles County have a full continuum of services available. There is a growing awareness of the need for a countywide plan and an approach to service delivery that assures the availability of appropriate services for all infants and their families.

B. Administration: Improving Inter-Agency Communication and Coordination

Improvement in inter-departmental communication and coordination is essential both at the state and local levels. The complexity of the existing service delivery system in Los Angeles County is staggering. A number of agencies are funded to deliver specific services, ranging from periodic screenings to comprehensive five day per week programs. Diverse program models have been developed to meet the needs of special populations.

Eligibility for programs varies widely, depending on the funding agency and the laws and regulations governing the agency.

Despite the complexities, many infant programs in the public and private sectors are operating successfully throughout the county. Careful consideration must be given to each program so as not to jeopardize its valuable service. Planning should provide for the utilization of both public and private agencies in order to build a collaborative service mode.

C. Eligibility: Definitions and Eligibility for Services

Eligibility for services must be interpreted uniformly throughout the county. Eligibility criteria should be flexible enough to include infants with identified disabling conditions as well as infants at high risk of developing future disabilities.

In making the final determination about eligibility criteria, consideration should be given to the following definitions offered by T.D. Tjossem of the National Institute of Child Health and Human Development:

1. Established risk.

"Established risk infants are those whose early appearing aberrant development is related to diagnosed medical disorders or known etiology bearing relatively well known expectancies for developmental outcome within specified ranges of developmental delay. The early medical, educational, and social interventions employed with these children are aimed at aiding them to develop and function at the higher end of the range for their disorder." An infant with Down's Syndrome represents an example of this risk category.

2. Environmental risk.

"Environmental risk applies to biologically sound infants for whom early life experiences, including maternal and family care, health care, opportunities for expression of adaptive behaviors, and patterns of physical and social stimulation are sufficiently limiting to the extent that, without corrective intervention, they impart high probability for delayed development." An abused or neglected infant falls into this risk category.

3. **Biological risk.**

"Biological risk specifies infants presenting a history of prenatal, perinatal, neonatal, and early development events suggestive of biological insult(s) to the developing central nervous system and which, either singly or collectively, increase the probability of later appearing aberrant development. Early diagnosis of enduring developmental fault is often difficult and inconclusive in these biologically vulnerable infants who, most often, require close surveillance and modified care during the early developmental years." Babies born quite prematurely, low birth weight infants, and/or those who experience extensive birth complications are examples of infants at biological risk.

4. **Medical and environmental risk.**

There is a great discrepancy between the number of infants identified as needing intervention services and the number of school-age children identified as requiring special education. It appears that identifiable infants are primarily those with physical handicaps. In the main, these are "low incidence" disabilities. The largest number of school-age children served by special education fall in the category of learning disabilities, emotionally disturbed and/or language impaired. These children are generally not identified in infancy. It seems apparent that children with these problems come from the population of medically and environmentally at-risk infants. If these children are followed by appropriate medical, developmental and other services, early identification for intervention services. could be detected. For many of these infants early identification could truly prevent the need for later, more costly special education services. It is for this reason that medically and environmentally at-risk children are included with the eligibility groupings offered by T.D. Tjossem. They require systematic follow-up services and referral, when appropriate, to more complete intervention services. It is from this group of infants that the greatest amount of prevention and cost savings will accrue.

D. Funding: More Effective Use of Existing Funds and the Identification of New Funding Sources

The county's service delivery system should be designed to eliminate gaps in services and duplication of effort by existing agencies. The major planning focus must be to promote services for infants and their families through the effective use of existing services; however, some restructuring is inevitable in order to ensure a comprehensive early intervention service delivery system countywide.

An increase in the numbers of infants in need of services is anticipated due to (1) the increasing birth rate, (2) new technology to increase survival of low birth weight infants, and (3) the unavailability or limited availability of existing services statewide. Therefore, increased funding may be necessary in order to meet this need.

E. Data Collection: Systematic Recordkeeping of All Infants Found Eligible for Service

A single, uniform system should be established for the collection and storage of data pertaining to all infants found eligible for services. The data would serve to provide information to service providers across agencies. The information could also serve as the basis for individualized service planning and the establishment of projected service outcomes.

F. Quality Assurance: Standards and Guidelines for Programs and Personnel

In order to assure the development of quality infant programs, it is necessary to establish minimum personnel and program standards, as well as guidelines for optimal program development.

With early intervention being an emerging new field, program standards have yet to be implemented. Staffing levels and qualifications are a major consideration. There is a critical need for expertise in child development, as well as the specific area of disability. In the absence of program standards, a consistent process for monitoring and review of services to infants does not exist.

Where guidelines have been established, they have not developed consistently across agencies. While a variety of service options is desirable, there are no minimum standards or guidelines for establishing infant services.

III. ANTICIPATED OUTCOMES AFTER IMPLEMENTATION

A. Cost Effectiveness Resulting From Inter-agency Coordination and an Eventual Decrease in Number of Children in Need of Special Services

With effective inter-agency coordination, unnecessary overlapping of services will be eliminated. In addition, research shows that the earlier the intervention is done, the greater the savings. Disabilities left untreated are frequently compounded with age as are the costs needed to address them.

B. Parent Education

Parents will learn to work effectively with their child and will become the primary advocate in the acquisition of needed services.

C. Availability of Services

A well coordinated, multidisciplinary service system that includes an essential range of services will be available throughout the county of Los Angeles.

D. Data Collection

A central cross-agency data base will be established to provide appropriate agencies with vital information about each child assessed and found eligible for service.

Chairman MILLER. Thank you. 96-272, in part, was brought about because a judge in Louisiana said enough was enough. So, the State of Louisiana, get your kids back in the state, stop this inappropriate placement that he thought was in violation of the law and certainly was in violation of the children's rights and the parents' rights in terms of visitation and taking care of them and I think it was called the Gary W. case actually. I just wonder why—and prior to that, I guess one of the reasons that there was a response in even a State like Louisiana, given how little level of support that they had at that time, was the notion that if you are out of compliance with Federal law, you would lose your funding.

Now, this Administration does not believe in that. They believe that that is too heavy a hand for the Federal government to play, that we really ought to let the states do this however they will. But I am starting to believe, and this is—I am not talking about Los Angeles here but after listening to a number of states and traveling throughout the Country on this problem, I am starting to believe that by the failure to have that tool or that arrow in the quiver, is that what we have here, is we have people engaging in really a grand conspiracy to violate the Law.

We have social workers that are overworked so they do the best they can. We have lawyers who know that the social workers are overworked so they do not put any more pressure on them. We have judges that are trying to run 15 courtrooms so the social worker does not say to the judge you are not doing your periodic review, you are not giving time to this case. What you really have are well-intentioned people engaged in a conspiracy here that is now starting to, or certainly has over the last couple of years, victimized millions of children and their families.

I am hard-pressed and I am going through two more hearings on this subject. But I would be hard pressed not to just make the determination, and it is a personal one, because it obviously has no force and effect, that this whole system is in contempt.

[Applause.]

Chairman MILLER. No, that is not the point. The point is that it seems to me that we are not going to get the kind of attention that is necessary until the system has threatened to break down. The system has broken down but there is not an acknowledgement by policymakers.

Those of us in the Congress refuse to acknowledge that IV-B monies are inadequate and they are driving a system that is no longer service based but is in terms of maintenance based at any cost at any place. That clearly the State and the local governments are not responding in that manner. Even where they have taken additional steps in the last year or so obviously it appears, and we are going to hear from them in the next couple of weeks, but it appears that HHS is the leader of the band here because somebody from the ACLU said yesterday in our hearings from New York, you have to work if you want one of these audits by HHS.

There is no way—actually some state did, never to be disappointed. But there really is no oversight and we have been dogging them now for over a year to prove to us that they are engaged in oversight and there is, in fact, none. So, what they have said is you go ahead and violate the law. You do not have to engage, as you say, Judge, in all reasonable efforts. You do not have to prove. You can check the form any way you want. In fact, when we review in New York, the form is checked at "no", all reasonable efforts have not been made. It does not make any difference which way you check the form. And people in New York tell us, just as you have, Patricia, that it is not a moment for more money because they have lost control just in terms of management. They would rather have some desktop computers than more money in the sense of services at this point because they just cannot match up kids and where they are in the system.

I guess I am speaking to you collectively because I think that your testimony this morning is very, very powerful and I do not know that you intended that but I suspect, given the phrases you used in terms of providing additional evidence, that this system is really in contempt of the rights of these children and these families.

I listened for several hours of the day before to a young man with his mother sitting behind him in the audience, talk about he is now 12, for five years he tried to go home to his mother and how she tried to get him home. And all that ever happened to that family was that she had to go into the hospital for emergency care and there was nobody to take care of them. Five years later, she could not get those kids back. And, as this little boy said, that is not right, that is not fair. And he is right.

But I really appreciate you—I somehow think that it is the legal community that has got to grab this one by the neck. I do not think that—because, I will tell you, where we have had the greatest amount of reform, that is what happens. Some judge said hold on, not in my courtroom. Not in my courtroom do you go through this charade, you devour these kids in this process and of course, when that happens, then policymakers have to scramble just as you found out with the housing allowance. Once it was available, once it was there, HHS was not going to deny it, not in your lifetime.

Let me just say on that one Byron, I would appreciate it if you would get some information this coming week. We are about to go into the appropriations process and so our delegation can put out a letter to the Appropriations Committee, as they deal with the fiscal year after October 1st, saying we expect this program to continue and to be funded. I think the California delegation united with that along with Illinois and New York. But that would be helpful if we could get that started early on in the Appropriations bill—they will be reporting that bill in the next couple of weeks to the Committee.

Lillian, let me ask you something. How come you can do this program—and I have been meeting with people now for several weeks that tell me they cannot do this, that we need a new Federal law. They are asking for IV—where are we IV, A, B, C—H, is it 179 H, yeah IV-H. We did not know what the hell to name it though. But, because they cannot get this kind of specialized foster care although we have had specialized foster care available.

But, with respect to the AIDS babies and the drug addicted babies, and in Los Angeles that caseload is building up, it has not even stabilized at this point in the cost, obviously, to the hospital.

Ms. **Johnson**. Well, what happened was that, for example, the neo-natologist that does all the screening for the admission to the program, we pay for it by college grant. The nurse that is in the program is provided by public health. The psychologist who does the screening of the foster parents is provided by our training funds. And we got a foundation to give us—start-up funds.

Chairman **Miller**. So, you are just knitting this program together.

Ms. **Johnson**. Right. And what we did was—and it can be maintained now because we are starting to institutionalize it because the actual costs per day for these babies, including all of those—we took the cost of these people's salaries and our social work salaries is $90 a day as opposed to $425 which is the lowest amount of money per day in the hospital.

So, the thing that is important about this is that, again, it goes back not just to the fact that it is an inexpensive program, it is the quality of the foster parents that allows us to do the things that everyone here today has criticized the system for, which is to work very quickly with those natural parents to get those babies home where they belong.

If you look at the ten children that we have—that left our program, one has died and two, which we took in the program, were too old. So there were really seven that left the program. All of them have been returned home, five are returned home to their biological parents, four within 6 weeks after leaving the hospital. The 6 weeks time was used to train them with how to take care of the medical needs of these children by the foster parents. Two had no parents and they went into adoption. But I think that——

Chairman **Miller**. But how are you getting the higher reimbursement rate?

Ms. **Johnson**. We use the foster care fund. Because in California, four or five years they asked for the special board rate. What counties wanted to do at that time about dealing with special-need children. We had already implemented a therapeutic home project, a very small program and established this sort of level of care costs. At the time they asked us to submit a special board rate program, we did not. They said if you want to retain your existing plan for extra payments you can, and we did. And we have been audited consistently on it and they have not—except for respite. The State is now refusing to pay for our respite benefits. They said that you have to withdraw that from the payments because the Federal government will not pay for it.

Chairman **Miller**. Okay, so that is one area where your reimbursement rate falls through.

Ms. **Johnson**. Right, that part will definitely fall through. The County will have to absorb that but our county happens to be so encouraged by the results in 8 months, almost 9, of the 25 babies that we have taken in and our goal is 60 babies at any given time, that at this point, despite the deficit, are willing to absorb some loss.

Chairman **Miller**. Let me thank you for saying here that you think foster parents should be paid. I mean, this notion that poor children should have poor foster parents is to me just outrageous. You know, Jonathan Swift once had a modest proposal; we eat our children. I thought maybe we might just pay people to take care of them and the notion that somehow, if you make a buck doing this—and I understand this, you know, every system has a group of leaches on it and we watch them and they devour the children and some of them have done it for money, some have done it for their deviant behavior, what have you.

That is all there but the notion that we cannot try to provide people who have good stable families, but do not have the resources to take in another child that somehow, if we provide them some additional monies to do that, when you see the administrative overhead of shuffling these kids around, it is just an outrage to me and kind of guarantees that it will not work.

So, I really appreciate your saying that because I think it is hard for me to see how we solve this problem without moving in that direction. Because I suspect, just as we see, you know, we talk about all of the people who want to adopt children and there are also families there that would be more than willing to take in these children but just because they either have children who are in college or in school or what—you know, we all kind of live at our full station of life no matter what our income is, that is not available to them but with adequate reimbursement—you know, permanency may be achievable to a much greater extent than it is today.

Ms. **Johnson**. I do believe that—and just one more additional comment about foster parents is that historically we have treated them like lesser beings, that with respect and training and some stature given to their position in the community, I think the quality of care that they will give our children when it is necessary to have a child in foster care, will be so greatly improved.

Chairman **Miller**. Well, maybe that should be the requirement. Maybe that should be the entrance requirement just like you want to do anything else; you want to be a paralegal or you want to be a licensed vocational nurse, or whatever it is you want to do, maybe that is what you do and come back to us and we will reimburse you and provide you a stable rate. But, you know, this business of hunting and pecking and looking for people in the middle of the night and believe that we are doing something good, is just—I think again, it is one of those cases where the demographics, the make-up of the kids, the problems that they bring, the multiplicity of problems, just defies the old Norman Rockwell portrait of the foster parent and that is not to denigrate for a moment what those people have done but the supply is way out of kilter with the demand and those are just the new realities.

Let me ask a question here, where are we in terms of—we have been looking at some studies in terms of obviously early intervention with these kids in special education and fitting that into our cost effectiveness approach here in the Congress. Where are you with referrals from hospitals? I mean, how is this—how is the identification process started at the beginning?

Mr. **Ferkich**. Well, it is still complicated for us.

Chairman **Miller**. Is the burden on the parent to find you or how is this done?

Mr. **Ferkich**. Well, actually, if you are talking about the deaf and the blind, the system is pretty good and it is working.

Chairman **Miller**. Yeah.

Mr. **Ferkich**. But, other than that, it is still pretty much up to the parent and sometimes they will show up when the child is kindergarten age when, in fact, they might have been eligible for services prior to that.

Chairman **Miller**. Right.

Mr. **Ferkich**. So, what we have tried to do is publicize and get the information out that services are available but there just is not that communication, I think, that there needs to be between the hospitals and school systems and other agencies. And I think that is one of the major, major values of this interagency collaboration that we have and this task force and that is that we are getting to know each other, we are talking to each other, we are learning about what we all do. So, I see that really an answer to a lot of the breakdown in communication.

Chairman **Miller**. Is there an effort? I mean, is there some kind of effort trying to link that up between hospitals and infant toddler programs?

Mr. **Ferkich**. There is an effort in that we are actually going out, Ms. Mallis is actually going out and visiting a lot of those infant programs that are connected with hospitals and making herself known to the population out there. And that is really brand new.

Chairman **Miller**. Thank you. Well, thank you very much for your testimony. I think you may be able to tell you hit a responsive cord here. Thank you for your time and again, I would just ask that we be allowed to prevail on you a little bit longer in terms of soliciting some additional information from you that your testimony raises that there is no point in dealing with you in a public hearing but much of the testimony today raises—I have been making notes here all day, my staff will love to know this. But it just raises a whole series of issues that we are currently dealing with in other committees and I would like to be able to come back to you in that aspect. In some ways, that is the most valuable part of these kinds of hearings is to be able to connect this up to either—much of what Congressman Waxman is doing right now in terms of some of these services as mentioned in your testimony. It is sort of our effort to try to get that over to the other committees in the Congress.

And again, let me thank the School Board for their help and the use of the facilities and the Children's Services Commission here in LA for all of their outstanding help to us and to Supervisor Antonovich and Congressman Dreier for sharing part of their time with us.

The record will be kept open for a period of two weeks so that people who are in the audience who want to contribute something to this record or disagree with it or think that there is additional information that should be made available, please do not hesitate. It is the Select Committee on Children and Families, Washington D.C., and so, I think there was a sign-up list for people that want to be on the mailing list so that we can keep you kind of updated as to what transpires after a hearing like this. We try to make sure that this just is not the matter of binding it and putting it in readable form but that it is transmitted to those committees of jurisdiction and finds its way into the public debate.

So, thank you, very very much.

[Whereupon, at 1:42 p.m., the above-entitled matter concluded.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF EDMUND D. EDELMAN, SUPERVISOR, THIRD DISTRICT, BOARD OF SUPERVISORS, COUNTY OF LOS ANGELES, LOS ANGELES, CA

I commend the Select Committee on Children, Youth and Families for demonstrating its concern about children in crisis by holding this hearing. Virtually every drug abuse expert and every concerned person from President Reagan down to local law enforcement officials all recognize the very real crisis now endangering the nation because of widespread drug abuse. However, all but overlooked in this mounting public outcry is the potentially much more harmful long term effects drug use has on infants and children.

Just in Los Angeles County between 1981 and 1987, the number of cases involving drug addiction passed from pregnant mothers to their babies escalated by 1,100%. When county healthcare officials made me aware of this growing problem, I held a public hearing on perinatal drug abuse in December, 1985.

As a result of that hearing, the Los Angeles County Board of Supervisors unanimously approved my motion to create uniform hospital reporting standards to monitor the birth of drug-addicted babies as well as improving medical tracking for such infants. In addition, the Board accepted my recommendations aimed at alerting the public, especially expectant mothers, to the dangers of taking drugs or alcohol during pregnancy. Special pamphlets have been created for pregnant women and a public service bus placard and billboard campaign was launched on the risks of perinatal drug abuse.

Even with these steps, the number of cases involving infants in drug withdrawal as a result of their mothers' substance abuse continues to climb. We have discovered that babies born of drug-abusing mothers require special care and possibly long-term intervention. These infants are characteristically born prematurely, are poorly nourished and suffer from a variety of neurological abnormalities as a result of their exposure to drugs. Mental retardation and seizure disorders are now well recognized complications arising from fetal drug and alcohol exposure. Other problems include sleeping and feeding disorders, vomiting, diarrhea, tremors, high-pitched crying and excessive movements. Follow-up studies of these children have shown poor growth and developmental delays.

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In Los Angeles County, the Departments of Children's Services and Health Services are working together on both medical and drug treatment issues involving infants and small children. The Department of Children's Services is providing specialized training to foster parents on how to care for substance-exposed infants.

Another facet of this problem that has received little public attention but worries child welfare advocates is the correlation between AIDS, drug abuse and sexual molestation. Infants born of substance-abusing mothers and children who have been sexually molested appear to be at a greater risk of contracting Acquired Immune Deficiency Syndrome or AIDS-Related Complex (ARC). Child welfare professionals may soon be confronted with young children who are not only traumatized by the physical and developmental problems resulting from perinatal drug exposure or sexual abuse, but also may be faced with complex medical and life-threatening illnesses arising from AIDS or ARC as they grow into childhood and adolescence.

Currently the number of foster care placements involving children with AIDS or ARC in Los Angeles County are quite small. However, this problem impacts on the county in three ways. (1) It increases the already complex task of providing services for abused, abandoned and neglected children. (2) It affects the foster care providers in the county, most of whom are reluctant to accept children with AIDS. (3) It places an extra burden on the already overworked Children's Services staff, who must receive additional professional training to cope with the problem of AIDS placements.

In addition to creating a local task force to consider ways of dealing with this problem, we are reaching out to the private sector to develop an approach that involves the community in caring for and protecting children with AIDS and ARC. The county also is experimenting with various pilot projects and trying different intervention strategies to determine what works best. Our basic belief is that counseling and home-based care services will make the difference.

Los Angeles County faces some major obstacles in its attempts to deliver an appropriate level of services for abused and abandoned children as well as children with special medical problems. Chief among these limitations is the lack of adequate finances to do the job. The heart of the children's service system -- the relationship between the case worker and the child -- is under stress because of rising caseloads. In the Emergency Response Program, each worker now averages nearly 50 cases, severely limiting the amount of time available for any one child.

The development of appropriate placement resources for children with special needs requires coordinated action at the federal and state levels among the social service, developmental services, mental health and general health programs operated by those governments.

One thing seems clear to me: the increasing complexity of cases entering the Los Angeles County child welfare system demonstrates that the problem cuts across jurisdictional lines and is not the exclusive concern of any one level of government. What we need, almost as badly as more financial resources, is improved interaction between local, state and federal agencies.

Thank you for this opportunity to testify before your committee.

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PREPARED STATEMENT OF GLORIA MOLINA, COUNCILWOMAN, LOS ANGELES, CA

I am Councilwoman Gloria Molina. I am presenting the following comments on behalf of the City of Los Angeles.

Your hearing today on "Young Children in Crisis" is a timely one. We are indeed in the midst of a crisis--one in which the victims sadly are too young or too sick, too disabled or too abused to speak for themselves. At this very moment, disturbingly large numbers of young children are suffering because: their mothers had little or no pre-natal care; their parent or parents had little or no training on how to take good care of children; their parent or parents cannot find good quality, affordable and suitable child care for that part of the day or night when child care services are needed.

Our nation and our people are at a crossroads. We are at a point where we must resolve to take control of our lives and our future, if we are to remain a leader, economically and politically, among nations. We cannot continue to be such a leader--as we have been in the past--if we do not strengthen the social underpinnings that allow individuals in our society to go forward to achieve, to excel and to provide leadership in any and all areas of social endeavor. We cannot succeed as a nation, if large segments of our population are subsisting at or below poverty levels, are hungry and malnourished, are homeless, are ill-educated, or simply are excluded from equal opportunities to progress as human beings and to make contributions to society.

Needs

At the most basic level, this means that we should be very concerned with the health and well-being of our young people. Unfortunately, many infants and young children have become early victims of the health care crisis that we have in this state and throughout the nation. The poor and the less-educated especially are suffering because they cannot afford many health care services. Those who have Medi-Cal or Medicare insurance often are turned away from service providers who will not accept Medi-Cal or Medicare; or they are turned away because under-funded, under-staffed, under-equipped and sometimes badly managed service providers simply cannot handle any more patients.

Recent studies by the Children's Research Institute of California and the Southern California Child Health Network have found that more pregnant women in the State are giving birth without benefit of prenatal care. One pregnant woman in 13 gets no prenatal care at all or gets too little too late. The incidences of infant mortality, newborn deaths and low birthweight are steadily worsening throughout the State. According to one of these studies, in 1986 in Los Angeles County, there was only one obstetrician for every 707 Medi-Cal mothers. The so-called "safety net" is not working for low-income mothers and infants in this State. Admittedly, the educational, monitoring and medical services they need are expensive--but preventive, prenatal care certainly helps to reduce those costs.

Of particular concern to us in the City of Los Angeles is the fact that many pregnant mothers are not adequately informed about the harm that can be done to their fetuses by drugs and alcohol. Babies can be born with long-term neurological effects, learning disabilities and even drug and alcohol addictions because their mothers were ill-informed or ill-supervised during pregnancy. Again, prenatal counseling plays an important role in promoting the birth of healthy babies.

We also have the problem in Los Angeles of teenage mothers and fathers, many of whom are not yet ready or able to take on the important responsibilities of raising a child. It is probably true that all of us have had difficulties, at one time or another, in communicating with the generation that went before us, as well as with the one which has come after us. Parents of teenagers need to keep communication lines open and to give as much support and guidance as they can, for teenagers need to feel that they will continue to have a place in the family, even as they attempt to express themselves as individuals in an adult world.

But providing guidance and support to our children is not an easy task for many parents, especially when both parents or the single parent must work full-time to make ends meet. We therefore need to adapt our educational systems to this fact and provide our young people with supplemental training and education in adult responsibilities, such as parenting, managing a bank account and a household budget, and being wise consumers. Teen parents particularly should have access to special counseling and training that will assist them on their "fast track" route to adulthood.

Publicity over the problem of "latch key" children seems to have waned during the last couple of years, but we believe that the problem still remains a major one. Yes, the availability of child care services is on the increase--but we must make sure that these services also are affordable, physically accessible, competent, and adequately-staffed. If not affordable and/or accessible, we will continue to see children left unsupervised and potentially at risk of accident, injury, hunger, and loneliness. If affordable and accessible, of course we would hope also that the service providers are well-trained, qualified and able to do the job that working parents cannot do themselves.

Ideally, child care providers should be trained in first aid, nutrition and child development. They should provide a clean, safe environment. Their services should be available on a full-time and part-time basis and during flexible hours. As I will mention again later, we consider the cooperation of both public and private sector employers to be very important, as the location of child care on the work-site or nearby is highly desirable for parents of pre-school age children.

City Policies and Activities

The City of Los Angeles has adopted general policy statements on child care issues and women's issues which contain policies relevant to the subjects at hand.

Our Child Care Policy Statement includes support of legislative efforts which would expand and improve child care services in the City--for example, by reducing regulatory complexities relating to child care providers; providing or increasing grants and/or other funding for child care programs; providing for the construction, renovation and/or maintenance of child care facilities; and providing reasonable tax incentives for employers who offer child care services.

In addition, the City's child care policy includes a commitment to serve as a model employer in terms of the delivery of child care services to its employees; and the City encourages all other employers to address the issue of child care. The City has a full-time Child Care Coordinator and an appointed Child Care Advisory Board, charged with the task of increasing the availability of child care services throughout the City. Providing an example for others to follow, the City is in the process of establishing a child care center for City employees in the Civic Center. In a private sector project, the City encouraged 15 major companies to form a consortium to provide child care for their employees and others in the community; this center opened last year with space for 70 children, aged 2-5.

The City also intends to include child care objectives and goals, where appropriate, in the elements of the Citywide Plan and the various community plans and specific plans.

Further, we hope to institute procedures to expedite the necessary approvals and permits required for the construction of child care facilities and for projects which include the construction of child care facilities.

The City's Women's Issues Policy Statement includes a policy to support legislation which would encourage and promote special leave policies, while permitting managerial discretion, in order to accommodate employees with family responsibilities; such leave policies would include maternity leave, parental leave, child rearing leave and dependent care leave.

Under this policy statement, we support legislation which would provide accessible, affordable and quality pre- and post-natal care for all women and their infants; legislation which would provide adequate funding for family planning programs; legislation which would provide funding for programs to educate women about their special health needs; and legislation which would continue to fund food programs for women and children.

Consistent with these general policy statements, the City has gone on record in support of S. 1885 (Dodd), the proposed Act for Better Child Care Services (the "ABC" bill). This comprehensive bill would provide important funding for State programs that will make child care more affordable and accessible, especially for low and moderate income parents. It also would require the use of minimum standards, strengthen licensing enforcement practices, provide for referral and training programs, and recognize needs of special populations (such as handicapped ,foster, migrant, abused and young parent children)--all of which we believe would go a long way to enhance child care.

We also are supportive of other legislative efforts which propose financial incentives and liability and insurance reforms to encourage the growth of child care services.

In closing, I would like to say that solving the problems of young children at risk is only a partial remedy for the difficult situations in which so many families find themselves today. While prenatal care, parenting and child care programs are extremely important in and of themselves, a comprehensive "family economic policy" is the ultimate approach which should be taken. This encompasses the whole host of reforms that are needed in an integrated home-and-work environment, because home and work responsibilities must be coordinated by all working members of society. Dependent care (including elder care and child care) programs, alternative work schedules, family leave policies, and flexible fringe benefit options should be utilized by all employers as part of a coordinated effort to maximize opportunities for people to sustain their families and perform well on the job.

The City of Los Angeles already provides many of these benefits to its employees, including the use of accumulated sick time, vacation time or unpaid leave for maternity or family care purposes; provision of dependent health care insurance; and flexible work schedules. The City has completed a child care needs assessment survey and soon will provide on-site child care services for Civic Center employees, as noted earlier; the City also is conducting an inventory of City properties to identify potential sites for additional child care facilities. In addition, the City is examining ways in which private developers can be encouraged to include child care facilities within development projects.

The needs of young children at risk, of course, must be addressed as effectively and as soon as possible, because they and many of their parents not untypically are defenseless, or nearly so, against the many dangers that threaten them. At the same time, we believe that the problems of young children at risk should not be viewed in isolation but within the more comprehensive framework of family needs and should be solved as part of a broader "family economic policy." As so well promoted by Councilwoman Joy Picus, my colleague on the Los Angeles City Council and the co-chair of a Statewide Task Force on Family Economic Policy, this is a policy which permits and facilitates the coordination of family and work responsibilities. The better such a policy is formulated and carried out, the better we will function as a society and perform as a nation.

Prepared Statement of Yvonne Young, Founder of Human Rights for Grandparents & Grandchildren Now Known as Grandparents and Grandchildren, San Marino, CA

We grandparents organized in the State of California in 1983 to work with our legislators to pass laws that would keep the bond alive between a grandparent and grandchild. Our membership is now well over 1,000 grandparents, aunts and uncles, etc., located throughout the entire State of California.

In 1983 we worked with Assemblyman Gary Condit to pass AB 300 which gave grandparents the legal right to seek visitation with a grandchild where there was a divorce of the parents or death of one of the parents, and visitation was being denied.

Also in 1983, AB 1550 Johnson's bill for Minors visitation to be provided or arranged for by county welfare department staff with his or her grandparents.

September of 1986 we worked hard with Assemblyman Wayne Grisham for the passage of AB 2645 whereby minors adjudged dependent children of the court and removed from the custody of their parents, be first placed with a relative before given to a Foster Home. This law is not being lived up to and grandparents are spending thousands of dollars with attorneys bucking Social Service to get their grandchildren. And once the child is placed in a Foster Home, they will not release it, and the courts go by their recommendations.

The following quote from a California grandmother's Western Union Mailgram dated April 13, 1988 pretty well tells the story of the struggle that is still going on.

"Select Committee on Children, Youth & Families, Care of Yvonne Young, Human Rights for Grandparents and Grandchildren, San Marino, Calif. YOU SENT ME A FERVENT PLEA--TO SHOW UP FOR A MEETING--AN IMPORTANT MEETING ON OUR YOUTH. I WOULD GO TO THE MEETING AND TELL OUR STORY EXCEPT: (1) WHEN WE WROTE TO OUR CONGRESSMEN DURING OUR ORDEAL-WE WERE REFERRED BACK TO THE VERY AGENCY WE WERE BEING DISCRIMINATED AGAINST. (2) WHEN OUR GRANDCHILD WAS ABUSED IN A FOSTER HOME THE POLICE REPORT WAS LOST. (3) WHEN WE APPEALED TO THE PRESIDENT, THE GOVERNOR, THE MAYOR--NO ONE WOULD LISTEN. (4) WHEN WE APPEALED TO THE SOCIAL WORKERS THEY WOULD NOT LISTEN. (5) WHEN WE GOT FIVE DIFFERENT ATTORNEYS OUT OF FRUSTRATION BECAUSE NONE OF THEM COULD DO ANYTHING FOR US, (6) WHEN WE GOT A PSYCHIATRIST'S REPORT AND SENT IT TO THE SOCIAL WORKERS THEY WOULD NOT LISTEN, (7) WHEN OUR GRANDCHILD'S CASE WAS PUT INTO ADOPTION DEPARTMENT, WE FELT WE HAD LOST HIM FOREVER, BUT NO AGAIN--HE WAS ABUSED IN A FOSTER HOME, (8) WE HAD A DOCTOR EXAMINE HIM AND HE SENT A LETTER TO THE DIRECTOR OF SOCIAL SERVICES, SOMEONE FINALLY LISTENED. NOW THAT WE FINALLY WERE ABLE TO ADOPT HIM AFTER MY DAUGHTER AGREED TO RELEASE HIM FROM JAIL, I CANNOT PUT WHAT WE WORKED FOR IN JEOPARDY & WHAT'S MORE I DON'T

THINK THE ONLY ATTORNEY WHO LISTENED WOULD WANT US TO EITHER...YOU KNOW WHO I AM, YVONNE, AND YOU KNOW WHY I MUST STAY ANONYMOUS. PLEASE READ THIS AT THE MEETING-AND SIGN ME, THANKING GOD FOR HIS BLESSINGS AFTER GOING THROUGH HELL TO GET OUR GRANDCHILD."

Social Service advertises for Foster Parents, yet all over our State, grandparents are begging for their grandchildren in the courts but they can't get them. These are physcially & financially fit GP's.

Right now, I have a grandmother in Northern California who has given me Notarized authorization to tell her story. She and her husband divorced. The husband took the two grandchildren they had raised from birth and gave each child to a different family in the area. The grandmother was able to locate and retrieve one child and sought help from Social Service in locating them. Three months went by and although the Social Worker located the second child, she did not tell the grandmother saying she guessed she made a boo boo. Now the family that has that child will not give it up and the case is in litigation, with the Social Worker saying grandma has no right to the child so the siblings will be separated only to look for eachother upon reaching adulthood.

In this case, the attorney for the couple holding the child wrote to Social Service stating the case can be continued for years as a way of keeping the grandmother from getting the child back.

I have in some cases written nice letters to Social Workers at the request of grandmother (many who are young yet, healthy & financially able to raise a grandchild) with copies going to various legislators in Washington, D.C. and California, as well as to Mr. Loren Suter, Deputy Director, Dept. Social Service, and the Social worker releases the child reluctantly from the foster home.

Mr. Suter has written me to get the laws changed. I did, but it hasn't done much good at all, as they are not lived up to.

The interstate problem in such cases is also bad. We have a grandmother who previously lived in California. Her grandchildren are in separate foster homes in California and she resides in the State of Washington now and seeks the children legally. Parents of said children want her to have them, as the mother is incapable of taking care of them. The State of Washington Social Worker doesn't want the grandmother to have them, but the California one does. She travels down to California for the hearings, but it drags on and on and it looks like the Social Worker in Washington will win out unless someone steps in to help. There are many other interstate problems besides this one.

Many times, it is the grandparents who while having their grandchildren in their home for visits see that they are being sexually or physically abused. They take the children to doctors and hospitals or the police and report it. The children are removed from the parents home by Social Service, but not given to grandma who reported it, and put in foster homes while the parents go through therape. After the children are returned to their parents to live, the children's parents cut off all visitation by the grandparents. Now these children have no one to go to should it happen again, and no matter how hard they fight in the courts, they are closed off from those grandchildren.

Because Social Workers are so bogged down with cases as has been documented in many newspaper articles, maybe their work load could be relieved by their many trips to court keeping well qualified relatives from getting minor abused and neglected children.

In the exchange of correspondence with a legal representative within the State of Tennessee's Government, he asked me if anything was being done about the ads in their papers placed by California individuals, Baby Brokers, with California babies for sale. To this date, I have not heard that anything is being done about this either.

The Baby Brokers many are attorneys I have been told by cases sent to me by the grandmothers trying to adopt said illigitimate grandchildren. The baby broker convinces an unmarried underaged pregnant girl to sell her baby after it is born. He will put her up along with another pregnant girl in a condominium until the birth. In the meantime, the sale is arranged. When the baby is born, it's spirited away to the buying couple. The baby broker then brings in a qualified doctor to court to testify that the real grandmother should not have the baby because it is now bonded to the buying parents. SAD INDEED. THE COURT, OF COURSE, AGREES with the doctor.

Assemblyman Rusty Areias, of California, tried to get a bill passed (1221) whereby instead of putting children into a foster home and not giving it to a grandmother or relative wanting it due to the lack of funds, did not pass. It would provide for the grandma or relative wanting the child to be paid by the state instead of paying a foster parent because the State doesn't have enough Foster Homes. It did not pass. This would keep families together also. So, let these children search for their families in later years, so what! Who cares? The children and their grandparents care though.

In 1985 all of our newspapers carried the story of 2 yr. old Isaac Lupercio who was beaten to death because his grandmother could not make the County's Dept. of Children's Services believe that her daughter and boyfriend were her heroin addicts and that she should have the child. "I've asked the county to give us copies of their records," she said. "We've called and left messages, but no one ever returned our calls. Then they told us that Isaac's records are private and we can't see them." The Grandmother also had taken the child to a hospital full of bruises on two occassions. The Los Angeles Police Detective on the case also recommneded the grandmother get the child, BUT NOBODY LISTENS TO ALL THE WARNINGS AND THE CHILDREN DIE.

This report is not a putdown for Social Workers, Foster Homes or Children's Services, etc., but to try and alert someone to do something to make them see ahead. Also to try and prove that the grandmothers trying to protect their grandchildren and gain custody of them is an act of love and devotion and protection for that child. Also to try and keep the family together even if the children cannot be with their own parents due to bad circumstances involving drugs, abuse, neglect and so forth.

PREPARED STATEMENT OF JACQUELINE DOLAN, CHAIRMAN, LOS ANGELES COUNTY FOSTER CARE NETWORK OF CHILDREN'S RESEARCH INSTITUTE OF CALIFORNIA (CRIC)

Hon. Leonard Edwards
San Jose
[illegible]

APRIL 15, 1988

MY NAME IS JACQUIE DOLAN AND I AM A VOLUNTEER ADVOCATE FOR ABUSED AND NEGLECTED CHILDREN SERVING AS CHAIRMAN OF THE LOS ANGELES COUNTY FOSTER CARE NETWORK OF THE CHILDREN'S RESEARCH INSTITUTE OF CALIFORNIA (CRIC) AND A MEMBER OF THE FOSTER CARE POLICY BOARD OF CRIC

THANK YOU FOR THE OPPORTUNITY TO SPEAK TO YOU TODAY ON THE ISSUE OF "YOUNG CHILDREN IN CRISIS: TODAY'S PROBLEMS AND TOMORROW'S PROMISES"

FACTS:

NATIONALLY:

OF THE CHILDREN WHO WILL BE ENTERING FIRST GRADE THIS YEAR:

ONE IN FOUR WILL BE POOR

ONE IN FIVE WILL BE TEEN PARENTS

ONE IN SIX WILL HAVE NO HEALTH INSURANCE

IN LOS ANGELES:

1986 NEWBORN DRUG RELATED BIRTHS NUMBERED 915

1987 NEWBORN DRUG RELATED BIRTHS NUMBERED 1,442 - AN INCREASE OF 527 - MORE THAN 50%

THE CALIFORNIA FOSTER CARE NETWORK WAS ESTABLISHED IN 1981 BY THE CHILDREN'S RESEARCH INSTITUTE, AND FUNDED BY CALIFORNIA FOUNDATIONS, TO INVOLVE CONCERNED CITIZENS IN CALIFORNIA WITH THE ISSUES SURROUNDING THE TREATMENT OF FOSTER CHILDREN IN THE STATE. THE EIGHT REGIONAL NETWORKS HAVE WORKED IN OUR LOCAL COMMUNITIES TO MONITOR THE IMPLEMENTATION OF PL 96-272 & SB14. THE NETWORK ALSO ASSISTS IN MAKING IMPROVEMENTS IN THE CARE OF FOSTER CHILDREN AT BOTH THE LOCAL AND STATE LEVELS. THE FOSTER CARE NETWORK HAS INITIATED A THREE YEAR PROJECT ON EMERGENCY SHELTER CARE IN CALIFORNIA, TO ASSESS THE PROBLEMS AND TO DEVELOP RECOMMENDATIONS FOR IMPROVED SERVICES FOR THE CHILDREN IN SHELTER CARE.

A PRELIMINARY STUDY OF ELEVEN MAJOR COUNTIES IN CALIFORNIA (OF 58) HAS BEEN COMPLETED BY THE PROJECT. ANOTHER TWENTY COUNTIES ARE CURRENTLY BEING SURVEYED. TO DATE, THE DATA IS CORROBORATING THE INFORMATION THE NETWORKS HAVE BEEN CONCERNED ABOUT: THERE ARE INCREASING NUMBERS OF CHILDREN ENTERING SHELTER CARE AND THEY ARE BRINGING WITH THEM INCREASINGLY MORE DIFFICULT PROBLEMS.

THE NUMBER OF CHILDREN IN SHELTER CARE, AS REFLECTED BY THE AVERAGE MONTHLY CENSUS IN THE ELEVEN COUNTIES, HAS INCREASED 83% BETWEEN 1983 AND 1987. THE CHILDREN ARE YOUNGER: 71% ARE AGE 10 OR BELOW, AS COMPARED WITH APPROXIMATELY 52% WHO WERE AGE 10 OR YOUNGER IN THOSE COUNTIES IN 1984-85. THE AVERAGE LENGTH OF STAY IS 37 DAYS, WHICH ENCOMPASSES STAYS OF 2 DAYS TO 150 DAYS. COUNTIES REPORTED THIS HAS INCREASED OVER THE LAST 3 YEARS. WHEN CHILDREN LEAVE SHELTER CARE, APPROXIMATELY 41% GO HOME OR TO RELATIVES, AND ABOUT 55% GO TO FOSTER HOMES, GROUP HOMES OR RESIDENTIAL TREATMENT CENTERS.

THE ELEVEN COUNTIES IN THE SURVEY REPORTED A GROWING LEVEL OF EMOTIONAL AND BEHAVIORAL DISTURBANCES ON THE PART OF CHILDREN ENTERING SHELTER CARE. AN AVERAGE OF 32% OF THE CHILDREN IN CENTRAL SHELTER FACILITIES ARE EMOTIONALLY DISTURBED OR MENTALLY ILL. SOME COUNTIES REPORTED AS MANY AS 60% OF THE CHILDREN IN SHELTER ARE DISTURBED. APPROXIMATELY 32% OF THE CHILDREN IN SHELTER ARE THOSE WHO ARE "REPEAT PLACEMENT" CHILDREN. THESE ARE CHILDREN WHOSE FOSTER PLACEMENT HAS FAILED AND THEY HAVE BEEN REPLACED IN A SHELTER FACILITY. THESE FAILURES ARE OFTEN A RESULT OF THE DIFFICULT BEHAVIORS OF THE CHILDREN AND A LACK OF APPROPRIATE PLACEMENT OPTIONS SO THAT CHILDREN CAN BE MATCHED WITH CAREGIVERS.

INCREASINGLY, THERE ARE INFANTS ENTERING SHELTER CARE WHO ARE ALCOHOL OR DRUG DEPENDENT BECAUSE OF THEIR MOTHER'S INGESTION DURING PREGNANCY.

A RECENT SURVEY BY THE ALAMEDA COUNTY SOCIAL SERVICES AGENCY FOUND THAT CHILDREN NEEDING SPECIAL MEDICAL CARE CONSTITUTE 34% OF THE FOSTER CARE POPULATION. THIS INCLUDES CHILDREN WHO REQUIRE SPECIAL MEDICAL REGIMENS (INJECTIONS, INTRAVENOUS MEDICATION, ETC.) INFANT DRUG ADDICTION, FETAL ALCOHOL SYNDROME, AND OXYGEN DEPENDENT CHILDREN.

MANY OF THE CHILDREN WHO HAVE SPECIAL MEDICAL NEEDS CAN BE CARED FOR IN A FOSTER FAMILY SETTING, RATHER THAN LANGUISHING IN A HOSPITAL. HOWEVER, THESE FOSTER FAMILIES NEED TRAINING ANF A RICH MIX OF SUPPORT SERVICES (MEDICAL AND SOCIAL) TO BE ABLE TO PROVIDE THESE CHILDREN WITH THE BEST ENVIRONMENT POSSIBLE. a HIGHER RATE OF REIMBURSEMENT IS REQUIRED TO ATTRACT, TRAIN AND RETAIN THESE SUBSTITUTE FAMILIES WHO WILL FIND THEMSELVES CARING FOR EXTRAORDINARILY DIFFICULT CHILDREN ON A 24 HOUR A DAY BASIS. cURRENTLY, WHERE FOSTER PROGRAMS FOR MEDICALLY NEEDY CHILDREN EXIST IN CALIFORNIA, THEE FAMILIES ARE BEING SUPPORTED WITH SOCIAL SECURITY TITLE IVE MAINTENANCE FUNDS.

FEDERAL LEADERSHIP IN PROVIDING PREVENTIVE SERVICES FOR SKILLED FOSTER FAMILY HOMES FOR MEDICALLY NEEDY CHILDREN WOULD ADDRESS TWO OF THE MOST PRESSING CONCERNS ABOUT THE FOSTER CARE SYSTEM TODAY. MANY OF THE CHILDREN WHO ENTER SHELTER FOR A VERY SHORT PERIOD MIGHT BE ABLE TO REMAIN AT HOME WITH THE PROVISION OF SERVICES. FUNDING EARMARKED FOR SPECIFIC PREVENTIVE SERVICES, SUCH AS IN-HOME CARETAKERS, DAY TREATMENT, EMERGENCY FAMILY CARE OR DAY CARE HAS NEVER BEEN ADEQUATE. PREVENTIVE SERVICES IN CALIFORNIA ARE FUNDED BY LOCAL CHILDREN'S TRUST FUNDS AND BY STATUTE PASSED IN 1982 WHICH PROVIDES AN ANNUAL APPROPRIATION FOR INNOVATIVE CHILD ABUSE PREVENTION AND TREATMENT SERVICES.

FEDERAL LEADERSHIP IS NEEDED TO PREVENT CHILDREN FROM ENTERING SHELTER CARE WHENEVER APPROPRIATE AND TO PROVIDE FOR THE CARE, IN HOME-LIKE SETTINGS, FOR FOSTER CHILDREN REQUIRING SPECIAL MEDICAL CARE.

PREPARED STATEMENT OF ELOUISE ROBERTSON OKOROMAH, A PARENT SERVED BY THE PROGRAM AT CRYSTAL STAIRS, INC.

I was introduced to this Program by a social worker while I was in the hospital being treated for depression. I was going through a divorce. I was at the point of giving upon my life. I could not function. Everything upset me, even my daughter. I loved my daughter, but her presence reminded me of her father. I also did not have the parenting skills necessary to understand the needs of my daughter. I feel it was the lowest time of my life.

This is when Crystal Stairs and their Respite Program came into my life. It has given me the time that I needed and still need to get my life in order. I am so thankful and grateful for thie program. This program has really helped me to put things in perspective. I really feel that if the hospital cosial worker had not referred me to this program, my daughter would have ended up in a foster home and I would not have had any reason to live. Crystal Stairs is like parents to me in the sense that I do not have parents. When something goes wrong in a child's life, the child can go to tthe parent for support. I really have to express the impact this program has made in my life. I was at the point that I really wanted to die. Nothing was important to me; not even my daughter. But, to tell you now, what this program has done for me has let me get my life in order.

I am now able to go to therapy, once a week. I am in College now. I will be fininshing in June, 1988. I have now remarried. Pretty soon,m I will no longer need the program. But I hope that this program will be there for others who may have need for its services in the future.

I also would like to add that the people that work for this agency are equally as important to me as the financial aspects of the program's help to me. One particular employee went beyond the course of her duties in order to see to my needs. Once again, I would like to express my feelings of appreciation to this Agency and it's programs.

PREPARED STATEMENT OF DONALD L. MARTIN, PH.D., PROJECT CONSULTANT, LOS ANGELES, CA

Homo sapiens, no matter their ethnicity, have at least three things in common. All require food, some type of body covering, and shelter to meet essential physical needs. On the psycno-social side of basic human needs, there is the need to belong, the enhancement of the self-concept and an exhaustive listing of the psycho-social variables.

Should a society intentionally deprive ANY group from those essentials needed to adaquately function in that society, it will have consciously released a monster that will not only devour the individual, but other segments of society as well.

It is no accident that a larger society, via negatively projected cues, can cause an inordinate number of persons in that society to be literally whittled away rather than polished and highly motivated by this "grindstone" called life. Undoubtedly life's grindstone will either polish one up or whittle one down depending on the stuff of which one is made. This nostrum however does not consider the environmental meanness that a hostile society can, and does, impose upon the conspicuously different.

Subject any group, or individuals, to prolonged states of insecurity, defilement, persecution, unresolved problems or unfulfilled needs, and one will make fertile feelings of dejection, hopelessness, social instability, anxiety, alienation and depression. Some individuals, however, under the same imposed stressful conditions are able to achieve a degree of homeostasis while others succumb to a lack of purpose or ideals thus resulting in a breakdown of the standards or values held by the excluding dominate society.

The street hoodlum is now in the process of being made.

The home will initially shape, to great extent, one born into any society. Should the home be the bastion of acute family problems intensified by community related problems, and failure complex pervading the entire household one can then, with a fair degree of certainty predict a climate of learned chaos for the younger members of the household. No attempt is herein made to absolve the individual of his responsibility to society. The individual was born into a society that has exclusive rules that neither the individual nor his family participated in making. Suffice it to say that privilege, role modeling, educational and economic opportunities all bear, in this society, a badge of ethnocentricity.

The making of the street hoodlum continues, for he was not born that way. The etiology of his pathology will not be solved by the utilization of more law enforcement officers, for this approach tends to address the results and not the root causation. Until this society ceases to penalize the individual for not being smart enough or sophisticated enough TO CHOOSE HIS OWN PARENTS then we will create even more street hoodlums. Until this society fairly addresses the economic problems of jobs and job training, mis-education of the culturally different, the infusion of drugs into communities where people suffer depression, our community will be unsafe for all... no matter their status in life, or the pigmentation of their skin.

4/8/88

lwv/lac

LEAGUE OF WOMEN VOTERS OF LOS ANGELES COUNTY

Connie Wills, Treasurer
2021 Marengo Avenue
South Pasadena, California 91030
(818) 799-3228

April 14, 1988

The Honorable George Miller, Chairman
Select Committee on Children, Youth & Families
U.S. House of Representatives
Washington, D.C.

Dear Congressman Miller;

The League of Women Voters of Los Angeles County, California recently completed a one year study of Foster Care in this county. We appreciate the opportunity to present to your committee a copy of our study guide and the conclusions our members reached as a result of the study by 15 local Leagues in Los Angeles County.

We have and will continue to speak to the Los Angeles County Board of Supervisors on issues affecting Foster Care. We would also like to enter into the record of the April 15, 1988 hearing on "Young Children in Crisis: Today's Problems and Tomorrow's Promises" a summary of our newly-adopted position on Foster Care:

> FOSTER CARE - Support for a foster care system which considers the needs and feelings of the child to be primary; offers supportive and preventive services to keep the natural family together when feasible; and provides a nurturing home-like environment to enhance the growth and development of children in foster care. Support for services to encourage reunification of the family or permanent placement as quickly as possible. Support for assessment, placement, support services, counseling, education and training which enhance the child's self-esteem and encourage rehabilitation and self-sufficiency in older dependent and delinquent youth. Support for effective training of all personnel and caregivers; enhanced recruitment of foster parents; adequate and promptly paid stipends reflective of costs of care; reasonable caseloads; encouragement of and cooperation with the private sector. Support for a Dependency Court which encourages long-term assignments of judicial personnel who are qualified and sensitive to the needs and feelings of abused, neglected and "at risk" children.

Sincerely,

Georganne Thomsen

Georganne Thomsen, 1st Vice President
1259 Winchester Ave., Glendale, CA 91201

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LEAGUE OF WOMEN VOTERS OF LOS ANGELES COUNTY

FOSTER CARE STUDY CONSENSUS

FOSTER CARE 1987-88

Support for a foster care system which considers the needs and feelings of the child to be primary; offers supportive and preventive services to keep the natural family together when feasible; and provides a nurturing home-like environment to enhance the growth and development of children in foster care. Support for services to encourage reunification of the family or permanent placement as quickly as possible. Support for assessment, placement, support services, counseling, education and training which enhance the child's self-esteem and encourage rehabilitation and self-sufficiency in older dependent and delinquent youth. Support for effective training of all personnel and caregivers; enhanced recruitment of foster parents; adequate and promptly paid stipends reflective of costs of care; reasonable caseloads; encouragement of and cooperation with the private sector. Support for a Dependency Court which encourages long-term judicial assignments for those who are qualified and sensitive to the needs and feelings of abused, neglected and "at risk" children.

POSITION PAPER ON FOSTER CARE

Support for the following:

1. Protective social services which:
   - a. Assist families to achieve and maintain safe, stable, nurturing home environments to enhance child growth and development.
   - b. Reduce need for separation of children from their families by providing services which will prevent or ameliorate conditions which overwhelm families.
   - c. Provide children with alternative nurturing arrangements in recognition of their right to freedom from sexual, emotional and physical abuse and neglect.
   - d. Assist youth to achieve independent living arrangements when this is the best solution.
   - e. Rehabilitate and reunite families as soon as they are able to provide nurturing home environments.
   - f. Assist in providing permanent nurturing care environments for children who cannot or should not return to their homes.
   - g. Provide counseling, education and training for dependent and delinquent children to enhance their self-esteem and encourage rehabilitation and self-sufficiency for older youth in foster placement.

LEAGUE OF WOMEN VOTERS OF LOS ANGELES COUNTY

2. A public foster care system which:
    a. Considers the needs and feelings of the child to be primary.
    b. Provides effective training for licensing personnel, evaluators, caseworkers, foster parents and others who have contact with abused, neglected and "at risk" children, their parents and foster parents.
    c. Encourages recruitment and training of foster parents by:
        (1) increasing public awareness of the need;
        (2) streamlining the application and licensing process;
        (3) providing positive support services and incentives;
        (4) giving constructive suggestions in a sensitive manner;
        (5) assuring that foster parents' stipend is at a level sufficient to cover all necessary costs, including foster parent training courses, transportation and child care and respite care when needed.
    d. Establishes and maintains a reasonable caseload limit which allows personnel sufficient time to properly assess, place, visit, assist and encourage each of their assigned children, foster parents and natural parents and to complete the essential records.
    e. Provides adequate funds designated for support services and programs to prevent out-of-homes placement whenever possible and to strengthen dysfunctional families when reunification is the objective.
    f. Gives priority to the development of a fast, efficient method of payments to caregivers and service providers.
    g. Seeks all possible funds from state and federal governments.
    h. Works with the private sector to encourage and coordinate the provision of services in the community for "at risk" children and their families.
    i. Develops and supports alternative programs and services, such as voluntary short-term placement, in-school counseling, day treatment centers for children and their parents, family life and parenting classes and early detection/intervention efforts.

3. A Dependency Court which:
    a. Is separate from the Criminal Court environment.
    b. Requires appropriate training of judges, commissioners, child advocates and other court personnel who work with children.
    c. Enhances and encourages long-term judicial assignments for those who are qualified and sensitive to the needs and feelings of abused, neglected and "at risk" children.
    d. Verifies that reasonable effort is made to maintain the child in his/her home or to reunite the child with the natural family, when it is safe and in the child's best interests.

[Study entitled "Foster Care in Los Angeles County", from League of Women Voters of Los Angeles County, 1987 is retained in Committee Files.]

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